

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENTS MADE IN ERROR FOR
PERSONAL CARE SERVICES
DURING INSTITUTIONAL STAYS**



Daniel R. Levinson
Inspector General

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OBJECTIVE

To determine (1) the extent to which five State Medicaid programs made payments in error for personal care services (PCS) during periods of beneficiary institutionalization and (2) what controls these States reported establishing to prevent those payments.

BACKGROUND

PCS provide the elderly, people with disabilities, and individuals with chronic or temporary conditions with the assistance that they need to remain in their homes or communities. State Medicaid programs may reimburse the cost of PCS for individuals who are not inpatients or residents of certain institutions but should not separately reimburse for personal care services furnished during institutional stays.

We reviewed Medicaid PCS and institutional claims and Medicare institutional claims for services provided from October 1 through December 31, 2005, in five States: Minnesota, New Mexico, North Carolina, Texas, and Washington. During the period of our review, these States paid a total of \$11.6 million for 29,057 claims for PCS that overlapped with the dates of institutional stays. We compared the dates of service for paid PCS claims with the dates of service for paid Medicaid and Medicare institutional stays to identify Medicaid payments for PCS provided during institutional stays. We also interviewed State Medicaid officials about the reasons the identified claims were paid and their efforts to prevent such payments.

FINDINGS

In the first quarter of fiscal year 2006, the five States reviewed paid nearly \$500,000 in error for personal care services provided during periods of institutionalization. In one quarter, Medicaid programs in the five States paid \$243,385 for 1,670 claims for PCS provided on days that Medicaid also paid for institutional care. These claims represented 43 percent of the PCS claims paid in error that we identified, using data that were available in the States' own Medicaid payment systems. The Medicaid programs also paid \$251,260 for 2,251 claims for PCS provided on days that Medicare paid for institutional care. State Medicaid officials volunteered that they do not have complete access to the information necessary to prevent payments for PCS provided during institutional stays paid by Medicare.

Billing practices in three States create vulnerabilities that could mean that up to \$11 million in one quarter may have been paid in error.

In one quarter, the Minnesota, Texas, and Washington Medicaid programs paid \$11.2 million for 26,929 PCS claims that overlapped with claims for institutional care. We determined that 7 percent of these claims were paid in error. However, because these three State Medicaid programs allowed PCS providers to bill for services using date ranges that included days on which no PCS were provided, we could not determine, using existing claims data, whether the remaining 93 percent of the overlapping PCS claims, representing approximately \$10.9 million, were paid in error.

Although all five States reported having controls to prevent Medicaid payments for personal care services provided during institutional stays, the controls did not prevent all erroneous payments.

All five State Medicaid programs had payment system edits and postpayment audits in place that were intended to prevent or recover payments for PCS during institutional stays, but they were not always completely effective. State Medicaid officials identified some reasons the identified claims were paid in error, including payment system edits that were not working properly and case managers' failure to terminate service authorizations.

RECOMMENDATIONS

The Medicaid programs in the five States reviewed paid \$494,645 in error for 3,921 claims for PCS provided during institutional stays in the first quarter of fiscal year 2006. However, payments made in error for PCS provided during institutional stays could total up to \$11.2 million in that quarter in three States that allowed PCS providers to bill using date ranges that included days on which no PCS were provided.

Therefore, we recommend that the Centers for Medicare & Medicaid Services (CMS):

Enforce existing Federal Medicaid payment policies that prohibit Medicaid reimbursement for personal care services provided over a range of dates if the range includes dates on which the beneficiary was institutionalized. CMS could accomplish this by including claims for PCS billed in date ranges in Medicaid audits and disallowing Federal expenditures for PCS claims that lack supporting documentation.

Work with States to reduce erroneous Medicaid payments for personal care services provided during institutional stays by:

- exploring ways to ensure that State Medicaid programs have complete information on Medicare institutionalizations for dually eligible beneficiaries to prevent payments for PCS during Medicare-paid institutionalizations (e.g., requiring admission dates on all crossover claims submitted to State Medicaid agencies);
- disseminating information to State Medicaid agencies regarding the vulnerabilities identified (e.g., payment system edit failures, untimely or inaccurate service authorizations) and the importance of educating PCS providers on policy prohibiting payment for PCS while beneficiaries are institutionalized; and
- including information regarding the vulnerabilities identified in the technical assistance and support provided to State Medicaid integrity programs by the Medicaid Integrity Group.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with the OIG recommendation to work with States to reduce erroneous Medicaid payments for PCS provided during institutional stays. However, CMS did not concur with the OIG recommendation to prohibit Federal Medicaid reimbursement for PCS claims billed with date ranges that include days on which no PCS were provided. CMS indicated that existing Federal reimbursement policies are sufficient to prohibit such payments when States have effective controls in place. We revised the recommendation to state that CMS should enforce existing Medicaid payment policies.

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OBJECTIVE

To determine (1) the extent to which five State Medicaid programs made payments in error for personal care services (PCS) during periods of beneficiary institutionalization and (2) what controls these States reported establishing to prevent those payments.

BACKGROUND

PCS provide the elderly, people with disabilities, and individuals with chronic or temporary conditions with the assistance that they need to remain in the community. The “State Medicaid Manual” describes PCS as assistance relating to eating, bathing, dressing, toileting, transferring, maintaining continence, personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.¹

Section 1905(a)(24) of the Social Security Act allows State Medicaid programs to furnish PCS as an optional benefit under the Medicaid State plan to individuals who are not institutionalized in certain types of facilities.² The statute specifies that Medicaid-funded PCS must be furnished in a beneficiary’s home or another location specified by the State. In addition, States may furnish PCS as home- or community-based services (HCBS) under a section 1915(c) waiver³ or under the mandatory home health benefit.⁴ Historically, section 1915(c) waivers have accounted for the majority of Medicaid spending on noninstitutional long term care, followed by State plan PCS and home health services.⁵ However, the Deficit Reduction Act of 2005 (DRA) allows State Medicaid programs greater flexibility to provide home- and community-based services, including PCS, without first seeking

¹ The “State Medicaid Manual,” Pub. No. 45, § 4480(C). Available online at http://www.cms.hhs.gov/manuals/downloads/P45_04.zip. Accessed on January 16, 2008.

² Coverage of PCS is optional except when such services are medically necessary to correct or ameliorate medical problems found as a result of an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening. Under section 1905(r)(5) of the Social Security Act, PCS are mandatory when medically necessary under EPSDT.

³ Social Security Act § 1915(c); 42 CFR § 440.180.

⁴ Social Security Act § 1905(a)(7); 42 CFR § 440.70.

⁵ “Medicaid 1915(c) Home and Community-Based Service Programs: Data Update,” Kaiser Commission on Medicaid and the Uninsured. December 2006, p. 4. Available online at <http://www.kff.org/medicaid/upload/7575.pdf>. Accessed on April 1, 2008.

approval for a Medicaid waiver. The Congressional Budget Office projects that, “By 2015, we expect that states with about one-quarter of enrollees would use [the DRA] authority to provide additional services to about 120,000 enrollees.”⁶ The option is projected to increase Federal costs by \$766 million over the 2006–2010 period and \$2.6 billion over the 2006–2015 period.⁷

State Medicaid programs are providing PCS and other HCBS to an ever-increasing number of Medicaid beneficiaries in efforts to contain increasing Medicaid spending, limit beneficiary institutionalization, and reduce long term care expenditures. Medicaid is jointly funded by the State and Federal Governments. Total combined State and Federal Medicaid expenditures for PCS alone reached \$9.4 billion in 2005, an increase of 56 percent over 3 years.⁸ Patterns in Medicaid long term care spending in recent years show that expenditures for personal care and home health services are increasing at a greater rate than expenditures for institutional long term care services.⁹ In fiscal year (FY) 2006, spending for personal care and home health services accounted for 40 percent of total Medicaid expenditures for long term care nationally and exceeded expenditures for any type of long term institutional care in 18 States.¹⁰ The rising Medicaid costs associated with home- and community-based services, including PCS, make it important to ensure that all payments for PCS are appropriate.

⁶ Letter to the Honorable Joe Barton regarding Medicaid provisions in S. 1932, the Deficit Reduction Act of 2005. Congressional Budget Office, January 31, 2006. Available online at: <http://www.cbo.gov/ftpdocs/70xx/doc7033/s1932medic.pdf>. Accessed on April 16, 2008.

⁷ Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act of 2005. January 27, 2006. Available online at: <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>. Accessed on April 16, 2008.

⁸ Centers for Medicare & Medicaid Services (CMS) Form CMS–64 summary data for 2002 and 2005. This was the most recent CMS–64 data available at the time of this report.

⁹ Kaiser Commission on Medicaid and the Uninsured. “Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000–2004.” May 2006, p. 7. Available online at <http://www.kff.org/medicaid/upload/7499.pdf>. Accessed on April 2, 2008. Office of Inspector General (OIG) analysis of data contained in this document supports this conclusion. These data were the most recent research data available at the time of this report.

¹⁰ Other types of long term care services include services provided in a nursing facility, an intermediate care facility for persons with mental retardation, or a psychiatric institution. State Health Facts, “Distribution of Medicaid Spending on Long Term Care, FY 2006.” Available online at <http://www.statehealthfacts.org/>. Accessed on January 16, 2008.

Medicaid Should Not Pay for Personal Care Services While the Recipient is an Inpatient or a Resident of an Institution

Under the Medicaid statute and regulations, State Medicaid programs should not separately reimburse for PCS provided to inpatients or residents of a hospital, a nursing facility, an intermediate care facility for the mentally retarded (ICF/MR), or an institution for mental diseases (IMD), hereinafter referred to as institutions.¹¹ Medicaid regulations also prohibit furnishing PCS under the home health benefit or under an HCBS waiver program to inpatients of a hospital, a nursing facility, or an ICF/MR.¹² The Medicaid programs in each of the five States included in this review allowed payments for PCS on the date of admission to an institution and, with the exception of Texas, the Medicaid programs in these States also allowed payments for PCS on the date of discharge from an institution. Payments for PCS on the dates of admission and discharge can be appropriate because the beneficiaries may have been at home for part of these days.¹³

Recent Office of Inspector General Work

In a 2006 report, OIG determined that little national information existed regarding the overall delivery of and reimbursement for Medicaid PCS.¹⁴ The lack of this information could increase Medicaid's vulnerability to claims and payments made in error for PCS during periods of institutionalization.

METHODOLOGY

We selected five States for this review: Minnesota, New Mexico, North Carolina, Texas, and Washington. We selected these States because they were in the top 25 percent of States in terms of national expenditures for Medicaid PCS in FY 2004.¹⁵ These five States represented 17 percent of total national Medicaid expenditures for PCS

¹¹ Social Security Act § 1905(a)(24); 42 CFR § 440.167.

¹² 42 CFR § 441.301(b)(1)(ii); 42 CFR § 440.70(c).

¹³ A State Medicaid Director Letter dated July 25, 2000, allows State Medicaid programs to make payments to PCS providers, under a home- and community-based services waiver, to allow beneficiaries to retain their caregivers for up to 30 days during institutional stays. Of the five States included in this review, only Minnesota allowed this type of payment for a small number of ventilator-dependent beneficiaries. We did not identify any beneficiaries receiving this type of payment in our claims analysis.

¹⁴ "States' Requirements for Medicaid PCS Attendants." OEI-07-05-00250.

¹⁵ CMS-64 summary data for 2004. These were the most recent CMS-64 data available at the start of our review.

alone in FY 2004, and personal care and home health services constituted at least 40 percent of Medicaid long term care spending in each of these States in FY 2004.¹⁶

All claims for Medicaid PCS that we examined in the five selected States were paid on a fee-for-service basis during the review period. Each of the five State Medicaid programs allowed PCS providers to bill Medicaid using date ranges rather than specific dates. North Carolina and New Mexico required that PCS be provided on every day in the date ranges billed. In Washington, Minnesota, and Texas, the date ranges represented billing periods, rather than actual dates of service; beneficiaries may not have received PCS on every day included in the date ranges.

Data Used in Analysis

From the five selected States, we obtained the following Medicaid data for the period October 1 through December 31, 2005:

- eligibility data for all beneficiaries enrolled in Medicaid,
- paid and denied Medicaid claims data for all PCS provided to eligible beneficiaries, and
- paid Medicaid claims data for all services provided in institutions.

To ensure that we identified all Medicaid- and Medicare-paid institutional stays for Medicaid recipients for whom PCS were claimed, we also obtained Medicare paid claims data from the National Claims History File. These claims represented all Medicare-paid institutional stays for Medicaid beneficiaries who received PCS from October 1 through December 31, 2005. To obtain this information, we matched the Social Security numbers contained in State Medicaid eligibility data with Social Security numbers contained in the CMS Enrollment Database to obtain Medicare Health Insurance Claims Numbers. We then used the Health Insurance Claims Numbers to identify Medicare claims for these beneficiaries.

Identifying Overlapping Personal Care Services and Institutional Dates of Service

Using the Medicaid data obtained from each of the five States, we matched the beneficiary identifiers and service dates on the Medicaid

¹⁶ State Health Facts, "Distribution of Medicaid Spending on Long Term Care, FY 2006." Available online at <http://www.statehealthfacts.org/>. Accessed on January 16, 2008.

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PCS claims against the beneficiary identifiers and service dates on the paid Medicaid institutional claims to identify overlapping dates of service. We then matched the beneficiary identifiers and service dates for all PCS claims against the beneficiary identifiers and service dates for paid Medicare institutional claims to identify overlapping service dates. Our matching program reflected State PCS payment policies as identified through discussions with State officials and documentation obtained. The identified claims described above will hereinafter be referred to as overlapping claims.

For analysis purposes, we combined multiple institutional stays with the same or consecutive admission and discharge dates into a single date range. For example, if a beneficiary was admitted to an institution on October 1 and discharged on October 7 and admitted to another institution on October 7 and discharged on October 10, we combined those two stays into one stay, lasting from October 1 through October 10. States' payment systems, which are based on their payment policies, may have allowed payment for PCS on October 7 because that was a discharge date for one stay and an admission date for the other stay. However, we considered October 7 from this example as part of an overlapping claim because the beneficiary was likely discharged from one institution and immediately admitted to another. The beneficiary likely would not have returned home on October 7, making payment for PCS inappropriate. For the first and last days of consecutive stays combined into single date ranges and all nonconsecutive stays, we applied the individual payment policies of the reviewed States to determine the accuracy of PCS payments on admission and discharge dates.

Determining Payment Errors for Overlapping Personal Care Services and Institutional Dates of Service

Medicaid Matches. The methodology used to identify PCS claims paid in error in each of the five States varied.

North Carolina and New Mexico—Because PCS providers in these two States had to provide care on every day within a PCS date range billed, any overlapping claim was an error (see Appendix A, Figure 1). State Medicaid officials confirmed that all of the PCS claims we identified were paid in error.

Minnesota, Texas, and Washington—Because PCS providers in these three States were allowed to bill using date ranges that included days

on which no PCS were provided, we were unable to determine which of the overlapping claims were paid in error without further review (see Appendix A, Figure 2). For the Minnesota claims, we reviewed PCS attendants' timecards to identify errors for the PCS claims that fell during Medicaid-paid institutional stays (see Appendix A, Figure 3);¹⁷ for the Texas and Washington claims, we performed further analysis on the dates and PCS units billed. We identified claims paid in error in these States by identifying instances in which beneficiaries were institutionalized for the entire PCS date ranges billed or the hours of PCS billed exceeded 24 hours of care per day. These methods are described in more detail in Appendix A.

If the PCS dates of service matched the dates of service for both Medicaid- and Medicare-paid institutional claims, we counted the PCS claim as a Medicaid match because the information needed to identify and prevent the overlapping dates was available in the State's own Medicaid payment systems.

Medicare Matches. Under the provisions of the Computer Matching and Privacy Protection Act of 1988, we were prohibited from providing State Medicaid officials with information regarding the PCS claims that we identified for services provided during Medicare institutional stays.¹⁸ Therefore, we used the same methodology utilized in Texas and Washington to identify PCS payments made in error for claims that overlapped with Medicare-paid institutional stays in all five States (see Appendix A).

Payment Calculations. We calculated the total amount (i.e., State and Federal shares) of Medicaid payments made in error for PCS provided during institutional stays. The methodologies by which the claims were identified necessitated different methods for determining payments made in error. Further details on how payments for PCS provided

¹⁷ Minnesota Medicaid officials provided timecards for 35 of the 41 PCS claims that overlapped with Medicaid-paid institutional stays.

¹⁸ The Computer Matching and Privacy Protection Act of 1988 (P.L. No. 100-503), amended by P.L. No. 101-508 (1990), established procedural safeguards and due process rights related to agencies' use of Privacy Act records in performing certain types of computerized matching programs. Because our evaluation did not undertake computerized matching to take action on individual claims or deny individual claims or recover payments to individual providers, we were not required to follow the procedures specified by the Act for those purposes and may not forward the results to the States to be used for those purposes. 5 U.S.C. § 552a(a)(8)(B).

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during institutional stays were calculated in each State appear in Appendix A.

Causes of Errors. We consulted Medicaid State agency staff in each of the five States to discuss controls established to prevent payments for PCS during institutional stays, the payment errors identified, and possible reasons those payments were made in error. We also discussed the methods used by the State officials to identify periods of beneficiary institutionalization and to detect and deny Medicaid claims for PCS during periods of institutionalization.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

In the first quarter of fiscal year 2006, the five States reviewed paid nearly \$500,000 in error for personal care services provided during periods of institutionalization

The five States that we reviewed paid \$11.6 million for 29,057 claims for PCS that overlapped with the dates of institutional stays in the first quarter of FY 2006. Of these, 3,921 claims (13.5 percent) were paid in error, totaling \$494,645 (4.3 percent).¹⁹ Table 1 provides an overview of total overlapping PCS claims and PCS claims paid in error in each State.²⁰ Appendix B contains further details on the number of beneficiaries and PCS claims in each State, overlapping claims identified, and the claims paid in error.

Table 1: Overlapping Claims and Claims Paid in Error, From October 1 Through December 31, 2005

	Overlapping Claims		PCS Claims Paid in Error			
	Number of Claims	Expenditures for Claims	Number of Claims	Percentage of Claims	Expenditures for Claims	Percentage of Expenditures
Minnesota	120	\$117,974	34	28.3%	\$6,504	5.5%
New Mexico	552	\$303,669	451	81.7%	\$124,134	40.9%
North Carolina	1,576	\$146,148	1,576	100.0%	\$131,521	90.0%
Texas	23,773	\$8,132,839	1,634	6.9%	\$171,917	2.1%
Washington	3,036	\$2,901,640	226	7.4%	\$60,569	2.1%
Total	29,057	\$11,602,270	3,921	13.5%	\$494,645	4.3%

Source: OIG analysis of claims data, 2008.

The billing practices of New Mexico and North Carolina enabled us to determine, using only claims data, which of the PCS claims that fell during Medicaid-paid institutional stays were paid in error. Our inability to provide State Medicaid officials with information regarding the PCS claims that fell during Medicare-paid institutional stays and the billing practices of the other three States required us to perform additional analysis to identify claims paid in error.²¹ However, this

¹⁹ All expenditures represent combined State and Federal shares.

²⁰ Each PCS claim represents services provided during a range of days, and payment for PCS could have been appropriate on some of those days. The expenditures in error represent only payments for the services provided on days within each range on which the beneficiary was in an institution.

²¹ All of the North Carolina Medicaid PCS claims that overlapped with Medicare-paid institutional stays had date ranges that either fell within the institutional stays or had more than 24 hours of services per noninstitutional day; hence, North Carolina's error rate in Table 1 is 100 percent. The other four States had some PCS claims that overlapped with Medicare-paid institutional stays that did not meet these criteria.

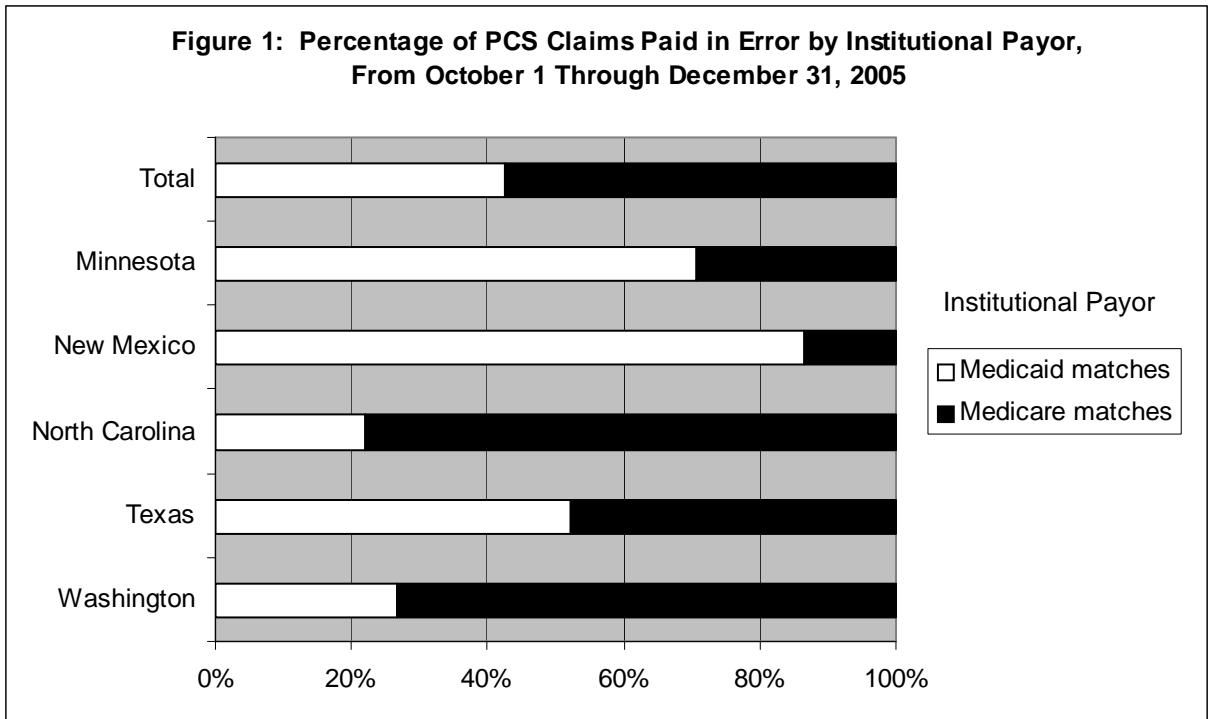
additional analysis could not identify every claim paid in error. Therefore, the error rates may be understated. We discuss the impact of States’ billing practices on our analysis and the error rates identified in the next finding.

State Medicaid programs paid \$243,385 for personal care services provided during Medicaid-paid institutional stays

In one quarter, Medicaid programs in the five States paid 1,670 Medicaid PCS claims, totaling \$243,385, for services provided on days on which Medicaid also paid for institutional care. The Medicaid matches represent 43 percent of the claims identified as paid in error as shown in Figure 1. The claims were identified using data that were available in the States’ own Medicaid payment systems.

State Medicaid programs paid \$251,260 for personal care services provided during Medicare-paid institutional stays

For the overlapping PCS claims that matched Medicare institutional stays, we identified instances in which beneficiaries were institutionalized for the entire PCS date ranges billed or in which the hours of PCS billed exceeded 24 hours of care per day for days on which the beneficiaries were not institutionalized. We identified 2,251 PCS claims, totaling \$251,260, that met these conditions. As described in



Source: OIG analysis of claims data, 2008.

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the methodology, this analysis did not enable us to identify all of the claims paid in error, so the error rate is likely higher than indicated. The Medicare matches represent 57 percent of the claims identified as paid in error. As previously noted, if a PCS claim matched the dates of both Medicaid- and Medicare-paid institutional stays, we counted it as a Medicaid match.

State Medicaid officials in three States volunteered that the lack of access to or incompleteness of Medicare institutional claims data available to them prevents them from identifying Medicaid payments for PCS during Medicare-paid institutional stays. The only Medicare information that State Medicaid officials reported receiving consistently was crossover claims.²² Medicaid officials in one State volunteered that the absence of institutional admission dates on crossover claims prevented them from using those claims to identify overlapping payments.

We analyzed overlapping Medicaid and Medicare payments to identify any patterns in provider types or institutional settings within and among the five States. We identified no patterns based on specific provider types or procedure codes.

Billing practices in three States create vulnerabilities that could mean that up to \$11 million in one quarter may have been paid in error

In the first quarter of FY 2006, Minnesota, Texas, and Washington paid \$11.2 million for 26,929 PCS claims that overlapped with Medicaid- and Medicare-paid institutional

stays. Because these three State Medicaid programs allow PCS providers to bill using date ranges that can include days on which no PCS were provided, existing claims data do not provide the information necessary to ensure that the overlapping claims are not paid in error. For example, a beneficiary was institutionalized from October 1 through October 7, and PCS were billed for the date range October 3 through October 9. In this scenario, we were unable to determine whether the PCS were provided between October 3 and October 6, when the

²² Crossover claims are claims for dually eligible beneficiaries sent to Medicaid for payment of the coinsurance and/or deductible on institutional services paid by Medicare.

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beneficiary was institutionalized, or between October 7 and October 9, when the beneficiary was at home.

In the three States, we could not determine whether claims for PCS were paid in error unless (1) beneficiaries were institutionalized for the entire PCS date ranges billed, (2) the hours of PCS billed exceeded 24 hours of care per day for days on which the beneficiaries were not institutionalized, or (3) we had access to timecards. Through our analysis, we determined that 1,894 (7 percent) of the overlapping claims in these three States were paid in error. However, using claims data alone, we were unable to determine whether the remaining 93 percent of the overlapping PCS claims, representing \$10.9 million, were provided during institutional stays. Therefore, the remaining 25,035 claims are at risk of being paid in error because States lack the information necessary to determine whether the claims were appropriate.

Although all five States reported having controls to prevent Medicaid payments for personal care services provided during institutional stays, the controls did not prevent all erroneous payments

All five State Medicaid programs had payment system edits and postpayment audits in place that were intended to prevent or recover payments for PCS during institutional stays, but they were not completely effective. For example, Minnesota, North Carolina,

and New Mexico had edits in place that disallowed payment of PCS on days when the beneficiary was institutionalized. Texas and Minnesota had edits in place that were designed to prevent authorizations for PCS and inpatient services from being entered for the same date. In Washington, case managers were required to create service authorizations for beneficiaries eligible to receive PCS, designating what services were payable on what dates. To stop the beneficiary from receiving PCS before the end of the service authorization period (i.e., because of the beneficiary's institutionalization), the authorization had to be manually terminated by the case manager. Additionally, Washington had instituted random postpayment audits comparing the hours billed to the hours recorded on PCS providers' timesheets and contracted with local Area Agencies on Aging to monitor PCS provider timesheets.

However, as evidenced by the claims identified in our analysis, these edits and audits were not completely effective. For example, in

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North Carolina and New Mexico, payment system edits were not working properly during the timeframe of our review and allowed payments for PCS provided during institutionalizations.²³ Minnesota had a payment edit in place to prevent payments for certain services during institutionalization, but it did not work for PCS claims because providers were allowed to bill using date ranges. Minnesota officials noted that, prior to our review, they were already implementing changes requiring providers to submit claims with exact dates of service to ensure that the payment edit would work in the future. Minnesota also planned to increase provider education on this issue, create clear documentation on payment guidelines, and implement an annual data check for PCS provided during institutional stays to recoup any payments made in error. In Washington, many of the overlapping claims were paid because case managers failed to close the service authorization when the beneficiary was institutionalized.

²³ In New Mexico, the malfunctioning edit was discovered and corrected early in 2006. In North Carolina, the malfunctioning edit was discovered and corrected in June 2007. Because these corrections were made after our review period, we cannot make any determination regarding their efficacy.

► R E C O M M E N D A T I O N S

In the five States reviewed, we identified 3,921 claims, totaling \$494,645, paid in error for PCS provided during institutional stays during one quarter. We also identified billing practices in Minnesota, Texas, and Washington that could mean that up to \$11 million may have been paid in error during the quarter. Because these three States allowed PCS providers to bill using date ranges that include days on which no PCS were provided, available claims data did not enable us to identify all payments made in error. For all five States, Medicaid officials lacked access to Medicare institutional claims data needed to identify PCS claims paid in error during Medicare-paid institutional stays. However, Medicaid matches represent 43 percent of the PCS claims paid in error and were identified using information contained in the States' own Medicaid payment systems. Finally, although all five State Medicaid programs had system edits in place and conducted postpayment audits, no program was able to prevent all erroneous payments for PCS provided during institutional stays.

Therefore, we recommend that CMS:

Enforce Existing Federal Medicaid Payment Policies That Prohibit Medicaid Reimbursement for Personal Care Services Provided Over a Range of Dates if the Range Includes Dates on Which the Beneficiary was Institutionalized

CMS could accomplish this by including claims for PCS billed in date ranges in Medicaid audits, and disallowing Federal expenditures for PCS claims that lack supporting documentation.

Work With States To Reduce Erroneous Medicaid Payments for Personal Care Services Provided During Institutional Stays by:

- exploring ways to ensure that State Medicaid programs have complete information on Medicare institutionalizations for dually eligible beneficiaries to prevent payments for PCS during Medicare-paid institutionalizations (e.g., requiring admission dates on all crossover claims submitted to State Medicaid agencies);
- disseminating information to State Medicaid agencies regarding the vulnerabilities identified (e.g., payment system edit failures, untimely or inaccurate service authorizations) and the importance of educating PCS providers on policy prohibiting payment for PCS while beneficiaries are institutionalized; and

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- including information regarding the vulnerabilities identified in the technical assistance and support provided to State Medicaid integrity programs by the Medicaid Integrity Group.

For this evaluation, we performed a computerized comparison of claims data for the purpose of examining State Medicaid payments. Under the provisions of the Computer Matching and Privacy Protection Act of 1988, we cannot forward the results to CMS or the States for purposes of denying individual claims or recovering payments to individual providers.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with the OIG recommendation to work with States to reduce erroneous Medicaid payments for PCS provided during institutional stays. CMS stated that Medicare should advise State Medicaid agencies of institutional stays for dually eligible beneficiaries and that the Medicaid Integrity Group would integrate the vulnerabilities identified in this report into its inspection criteria. CMS concurred with our recommendation to disseminate information to State Medicaid agencies regarding the vulnerabilities we identified. To better respond to one of the recommendations, CMS requested that OIG provide details surrounding why automated prepayment and postpayment system edits failed to prevent PCS payments made in error. We did not evaluate States' automated systems edits or the reasons edits failed, so we are unable to provide any further details regarding why edits did not prevent erroneous PCS payments.

However, CMS did not concur with the OIG recommendation to prohibit Federal Medicaid reimbursement for PCS claims billed with date ranges that include days on which no PCS were provided. CMS indicated that existing Federal reimbursement policies are sufficient to prohibit such payments when States have effective controls in place. We revised the recommendation to state that CMS should enforce existing Medicaid payment policies.

Finally, CMS indicated that any publicly released statements about the report should emphasize that the study was conducted in only five States and cannot be extrapolated nationally to other States or beyond the period covered by the evaluation. The full text of CMS's comments can be found in Appendix C.

Methodology Used To Identify Errors and Calculate Medicaid Payments Made in Error for Personal Care Services Provided During Institutional Stays

Medicaid Matches

The methods used to identify personal care services (PCS) claims paid in error for PCS provided during Medicaid-paid institutional stays are described below and illustrated in Figures 1–5 on page 19.

North Carolina and New Mexico. Because the New Mexico and North Carolina Medicaid programs allowed PCS providers to include only days on which PCS were actually provided in their date ranges, our analysis and State confirmation were sufficient to identify the payments made in error for PCS provided during Medicaid-paid institutional stays. As the example in Figure 1 illustrates, in North Carolina and New Mexico, because at least one service was provided on every day in the PCS date range, we know that the services provided on the overlapping days were paid in error.

Minnesota. The Minnesota Medicaid program allowed PCS providers to bill using date ranges that represented billing periods rather than actual dates of services; beneficiaries may not have received PCS on every day included in the date ranges. As Figure 2 illustrates, we were unable to determine using only claims data whether the PCS were provided between October 1 and October 4, when the beneficiary was at home, or between October 5 and October 7, when the beneficiary was institutionalized.

For Minnesota, we reviewed PCS attendants' timecards for 35 of the 41 PCS claims that fell during Medicaid-paid institutional stays to identify the days on which PCS were provided. By reviewing the timecards, we determined on which days PCS were actually provided during the date ranges billed. If PCS were provided on any day on which the beneficiary also received institutional services, we considered the PCS payment to be in error. As the example in Figure 3 illustrates, a beneficiary has a PCS claim with the date range from October 2 through October 8 and an institutional stay from October 4 through October 10. The timecard for his personal care attendant for October 2 through October 8 shows that services were provided on October 5 and October 6. Because those days are within his institutional stay, the payments for them were made in error.

Texas and Washington. The Texas and Washington Medicaid programs also allowed PCS providers to bill using date ranges that represented

billing periods rather than actual dates of services; beneficiaries may not have received PCS on every day included in the date ranges. As Figure 2 on page 19 illustrates, in these two States, we were unable to determine using only claims data, whether PCS were provided between October 1 and October 4, when the beneficiary was at home, or between October 5 and October 7, when the beneficiary was institutionalized. Additionally, Texas and Washington Medicaid officials were unable to review the claims identified or to provide timecards for our review because of the large volume of overlapping claims. Therefore, we used the following methodologies to identify claims paid in error in these States:

- (1) beneficiaries were institutionalized for the entire PCS date ranges billed (see Figure 4) or
- (2) the hours of PCS billed would exceed 24 hours of care per day for days on which the beneficiary was not institutionalized. If the hours provided would exceed 24 hours of care per day while the beneficiary was not institutionalized, any hours in excess of 24 would have to have been provided while the beneficiary was institutionalized (see Figure 5).

We consulted with Medicaid officials in these two States, who confirmed the validity of this analysis. However, this analysis could not identify all the claims paid in error.

Medicare Matches

The Computer Matching and Privacy Protection Act of 1988 prevented us from providing State Medicaid officials with information regarding the PCS claims that we identified for services provided during Medicare-paid institutional stays.²⁴ Therefore, we used the methodology illustrated in Figures 4 and 5 to identify PCS payments made in error for claims that overlapped with Medicare-paid institutional stays in all five States.

²⁴ The Computer Matching and Privacy Protection Act of 1988 (P.L. No. 100-503), amended by P.L. No. 101-508 (1990), established procedural safeguards and due process rights related to agencies' use of Privacy Act records in performing certain types of computerized matching programs. Because our evaluation did not undertake computerized matching to take action on individual claims or deny individual claims or recover payments to individual providers, we were not required to follow the procedures specified by the Act for those purposes and may not forward the results to the States to be used for those purposes. 5 U.S.C. § 552a(a)(8)(B).

Entire PCS date range falls within institutional stay. This test identified PCS claims with date ranges that were entirely within one or more institutional stays. As the example illustrated in Figure 4 shows, a beneficiary had a PCS claim with the date range of October 2 through October 8 and an institutional stay from October 1 through October 10. The date range of his PCS claim is entirely within the dates of his institutional stay, and therefore he was never at home to receive PCS on any of the days within the date range.

More than 24 hours of PCS were billed per noninstitutionalized day. This test compared the units of PCS billed to the number of days in the PCS date range on which the beneficiary was not institutionalized to determine which claims had more than 24 hours of PCS billed per day. As the example illustrated in Figure 5 shows, a beneficiary had a PCS claim with the date range from October 1 through October 8. He also had an institutional stay from October 4 through October 10. He was home only on 4 days in the PCS date range—October 1 through October 4 (the dates of admission and discharge are counted as at-home days). Therefore a maximum of 96 hours of PCS were possible during those 4 days. If more than 96 hours of services were billed, the beneficiary would have had to receive some of those services on days when he was institutionalized. We would have counted only the hours in excess of 96 hours in error. However, if fewer than 96 hours were billed, we had no basis to question the PCS claim, even if PCS were provided while the beneficiary was institutionalized. It is possible that some or all of these PCS claims were paid in error.

Medicaid Matches in North Carolina and New Mexico

Figure 1: Example of Overlapping Claims in North Carolina and New Mexico

Oct. 1	Oct. 2	Oct. 3	Oct. 4	Oct. 5	Oct. 6	Oct. 7	Oct. 8	Oct. 9	Oct. 10
PCS date range									
				PCS paid inappropriately					
Institutional date range									

Figure 2: Example of Overlapping Claims in Minnesota, Texas, and Washington

Oct. 1	Oct. 2	Oct. 3	Oct. 4	Oct. 5	Oct. 6	Oct. 7	Oct. 8	Oct. 9	Oct. 10
PCS date range									
PCS could be paid appropriately				PCS could not be paid appropriately					
Institutional date range									

Medicaid Matches in Minnesota

Figure 3: Example of Timecard Review

Oct. 1	Oct. 2	Oct. 3	Oct. 4	Oct. 5	Oct. 6	Oct. 7	Oct. 8	Oct. 9	Oct. 10
PCS date range									
				PCS paid inappropriately					
Institutional date range									

Medicaid Matches in Texas and Washington; Medicare Matches in All Five States

Figure 4: Example of Entire PCS Date Range Contained Within Institutional Stay

Oct. 1	Oct. 2	Oct. 3	Oct. 4	Oct. 5	Oct. 6	Oct. 7	Oct. 8	Oct. 9	Oct. 10
PCS date range									
PCS could not be paid appropriately									
Institutional date range									

Figure 5: Example of More Than 24 Hours of PCS Billed on NonInstitutional Days

Oct. 1	Oct. 2	Oct. 3	Oct. 4	Oct. 5	Oct. 6	Oct. 7	Oct. 8	Oct. 9	Oct. 10
4 noninstitutional days - max. 96 hours				PCS date range					
PCS could be paid appropriately				PCS could not be paid appropriately					
Institutional date range									

Calculation of Payments

North Carolina, New Mexico, Texas, and Washington. For these four States, the calculations of payments made in error for PCS provided during both Medicaid- and Medicare-paid institutional stays were the same. For PCS claims during which the beneficiary was institutionalized for the entire date range, the entire amount paid was counted in error. For these claims, the beneficiary was institutionalized and not at home at any point during the date range; no PCS should have been paid. For PCS claims in which the provider billed for more than 24 hours of PCS per noninstitutional day, we calculated the maximum possible hours of PCS that each beneficiary could have received while not institutionalized (e.g., 4 noninstitutional days x 24 hours per day = 96 possible hours of PCS). Only the portion of the payment associated with the hours in excess of the maximum possible hours was counted in error. Washington paid one type of PCS in units of 1 day. For these claims, if the beneficiary was institutionalized for part of the date range, we counted only days on which the beneficiary was institutionalized in determining the amount paid in error.

Minnesota. We employed different methods to identify PCS claims paid in error during Medicaid- and Medicare-paid institutional stays in Minnesota. Minnesota was the only one of the five States that provided timecards for the overlapping PCS claims. For the PCS claims that matched Medicaid-paid institutional stays, we reviewed the timecards to determine how many units of services were provided on days on which beneficiaries were in institutions. We then multiplied those units by the unit rate to determine the amount paid in error. Payment errors for PCS claims that matched Medicare-paid institutional stays were calculated similarly to those in the other four States as described above.


➤ A P P E N D I X ~ B

Personal Care Services: Total Beneficiaries, Paid Claims, Overlapping Claims, and Claims Paid in Error

First Quarter of Fiscal Year 2006	Minnesota	New Mexico	North Carolina	Texas	Washington
Number of beneficiaries enrolled in Medicaid	266,347	428,884	1,600,120	4,431,491	1,028,330
Number of beneficiaries receiving personal care services (PCS)	11,674	11,130	75,217	141,947	53,694
Number of beneficiaries who received PCS and Medicaid institutional services	636	951	10,446	14,393	1,926
Number of beneficiaries who received PCS and Medicare institutional services	163	637	2,895	7,473	2,450
Number of paid PCS claims	160,979	242,808	3,080,667	1,133,608	220,574
Number of PCS claims for beneficiaries who also received institutional services	10,161	24,229	396,480	154,794	12,559
Expenditures for PCS claims for beneficiaries who also received institutional services	\$4,230,738	\$16,471,359	\$24,500,100	\$39,227,964	\$11,445,130
Medicaid					
PCS claims that overlap with the dates of Medicaid-paid institutional stays	41	390	345	14,721	1,235
PCS claims for services provided during an institutional stay paid in error	24	390	345	851	60
Erroneous payments identified through claims review	N/A	390	345	N/A	N/A
Erroneous payments identified through timecard review	24	N/A	N/A	N/A	N/A
Erroneous payments identified through reasonableness tests	N/A	N/A	N/A	851	60
Claims in which the beneficiary was institutionalized every day in PCS range	N/A	N/A	N/A	826	55
Claims in which more than 24 hours of services/day were billed	N/A	N/A	N/A	25	5
Medicare					
PCS claims that overlap with the dates of Medicare-paid institutional stays	79	162	1,231	9,052	1,801
PCS claims for services provided during institutional stays paid in error, identified through reasonableness tests	10	61	1,231	783	166
Claims in which the beneficiary was institutionalized every day in PCS range	7	60	1,025	765	161
Claims in which more than 24 hours of services/day were billed	3	1	206	18	5

Source: Office of Inspector General analysis of claims data, 2008.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: JUN 05 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Wehras
Kerry Wehras
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Payments Made in Error for Personal Care Services During Institutional Stays" (OEI-07-06-00620)

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The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the OIG Draft Report entitled, "Payments Made in Error for Personal Care Services During Institutional Stays." The objectives of the report were to determine (1) the extent to which five State Medicaid programs made payments in error for personal care services (PCS) during periods of beneficiary institutionalization; and (2) what controls these States reported establishing to prevent those payments.

The CMS recognizes that PCS and other home and community-based services (HCBS) are expanding at ever increasing rates in concerted efforts by the States to hold down mounting Medicaid spending by reducing the incidences of beneficiary institutionalizations. Moreover, the Deficit Reduction Act of 2005 (DRA) allows the States even greater flexibility to provide HCBS (including PCS) without having to go through the Medicaid waiver application and approval process. The rising costs to Medicaid due to HCBS, including PCS, make it even more important to ensure that all payments for PCS are appropriate.

OIG Recommendation

Develop policy that prohibits Federal Medicaid reimbursement for personal care service claims billed with date ranges that include days on which no personal care services were provided.

CMS Response

The CMS does not concur with this recommendation to develop this policy because Federal Medicaid payment policies already exist that prohibit Medicaid reimbursement for PCS provided over a range of dates if the range of dates includes days during which

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Medicaid has also paid for institutional care for the beneficiary. As acknowledged by the OIG in the draft report, section 1905(a)(24) of the Social Security Act allows Medicaid programs to pay for the cost of PCS “furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease . . .” This statutorily mandated restriction is reiterated in Federal regulations at 42 CFR section 440.167. The development of additional Medicaid reimbursement policy is unlikely to impact a problem that appears to be caused by ineffectual controls within the States’ Medicaid Management Information Systems (MMIS). Nowhere in the draft report does the OIG assert that the erroneous payments were the result of weak or ineffective Medicaid payment or reimbursement policies. In fact, the OIG found that in all five States studied (Minnesota, New Mexico, North Carolina, Texas, and Washington) the States reported having controls to prevent Medicaid payments for PCS provided during institutional stays but that the controls did not prevent all erroneous payments. In light of this finding, it would seem that efforts by the States to improve their MMIS Claims Processing Subsystem edits and/or the functionality of their MMIS Surveillance and Utilization Review Subsystems would have a far greater positive impact on reducing erroneous payments, and we can encourage States to better examine their edits and systems to help eliminate these erroneous payments. However, because such controls are required elements of Federal MMIS policy (see State Medicaid Manual Chapter 11, section 11325, Claims Processing Subsystem and section 11335, Surveillance and Utilization Review Subsystem), additional MMIS policy development should also not be necessary.

OIG Recommendation

Work with States to reduce erroneous Medicaid payments for personal care services provided during institutional stays by exploring ways to ensure that State Medicaid programs have complete information on Medicare institutionalizations for dually eligible beneficiaries to prevent payments for PCS during Medicare-paid institutionalizations (e.g., requiring admission dates on all crossover claims submitted to State Medicaid agencies).

CMS Response

The CMS concurs with this recommendation. State Medicaid agencies should be advised by Medicare whenever dually eligible beneficiaries are admitted by Medicare for inpatient services or are institutionalized for any duration.

OIG Recommendation

Work with States to reduce erroneous Medicaid payments for personal care services provided during institutional stays by disseminating information to State Medicaid agencies regarding the vulnerabilities identified (e.g., payment system edit failures, untimely or inaccurate service authorizations), and the importance of educating PCS providers on policy prohibiting payment for PCS while beneficiaries are institutionalized.

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CMS Response

The CMS concurs with this recommendation. However, CMS would request that the OIG report provide some details surrounding why the automated pre- and post-payment system edits failed and allowed these PCS payments to be made in error. Since the second objective of this report is to examine what controls the States reported establishing to prevent those payments, it would be useful to discover why the system edits and alerts failed to stop these erroneously billed payments. By knowing this information, CMS will be in a better position to disseminate useful information to the States that can actually reduce erroneously billed PCS payments.

OIG Recommendation

Work with States to reduce erroneous Medicaid payments for personal care services provided during institutional stays by including information regarding the vulnerabilities identified in the technical assistance and support provided to State Medicaid integrity programs by the Medicaid Integrity Group.

CMS Response

The CMS concurs with this recommendation. The Medicaid Integrity Program was established by Congress through the DRA, and CMS has been building the program and the associated organization, the Medicaid Integrity Group (MIG), since then. The MIG will explore various ways to include information regarding the PCS payment errors and vulnerabilities identified in this OIG report as a part of the technical assistance and support that it provides to the States. For example, the MIG will look into integrating these PCS payment irregularities into its inspection criteria for the staff assistance visits conducted with the various State Medicaid agencies. The MIG staff completed eight pilot, comprehensive State program integrity reviews in fiscal year (FY) 2007. An additional 19 such visits are planned in FY 2008 and 18 more are planned in FY 2009. In addition, in accordance with provisions in the DRA, the MIG will be hiring contractors by FY 2009 to educate providers on payment and billing integrity as well as quality of care issues.

Other Comments

We have the following general comment on the draft report: Any publicly released statements about the report should emphasize that the study was conducted in only five States and cannot be extrapolated nationally to other States or beyond the timeframe of the report evaluation.

Once again, CMS thanks the OIG for the opportunity to review and comment on this report.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Deborah Walden served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Emily Meissen, Elander Phillips, and Michala Walker; other central office staff who contributed include Kevin Manley and Scott Horning.