



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

November 3, 2008

TO: Jackie Gamer, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services

FROM: Michael J. Armstrong
Regional Inspector General for Audit Services, Region I

A handwritten signature in black ink that reads "Michael J. Armstrong".

SUBJECT: Partnership Review of Medicaid Claims Processed by Cerebral Palsy and Stavros
for Personal Care Attendant Services Provided to Beneficiaries during Inpatient
Stays (A-OI-08-0000I)

We are transmitting, for your information and use, the attached final report on the partnership review of Medicaid claims processed by Cerebral Palsy and Stavros for personal care attendant (PCA) services provided to beneficiaries during inpatient stays from October 1, 2004, through September 30, 2005. This review was conducted by the Massachusetts Office of the State Auditor (OSA) and our Office of Inspector General (OIG). The objective of the review was to determine if Cerebral Palsy and Stavros processed claims for PCA services provided to beneficiaries during inpatient stays.

OSA's report was issued to the Massachusetts Executive Office of Health and Human Services (the State agency). We participated in the OSA review by providing the 200 sampled items and technical assistance for each phase of the review. We also performed a desk review on each of the errors identified once OSA had completed its analysis of the sample. Therefore, we believe that the attached OSA audit report is reliable and can be used by the Centers for Medicare & Medicaid Services in meeting its program oversight responsibilities.

The State agency administers the Medicaid program and is responsible for processing PCA service claims. Cerebral Palsy and Stavros are contracted to provide fiscal intermediary services on behalf of the State agency. Section 1905(a)(24) of the Act authorizes payment for PCA services for a beneficiary "who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or an institution for mental disease"

OSA documented that 118 out of the 200 sampled paid claims processed by Cerebral Palsy and Stavros were for PCA services provided to beneficiaries during inpatient stays. In addition, OSA determined that the State agency's internal controls and procedures were inadequate to prevent or detect overpayments for PCA services provided while the beneficiaries were residents of either nursing facilities or other inpatient facilities.

Based on the results of the review, GSA recommended that the State agency strengthen its internal controls and oversight over payments for PCA services to ensure that it does not pay for noncovered services, including those provided to beneficiaries who are residents of nursing facilities or other inpatient facilities. Furthermore, GSA recommended that the State agency collect the estimated \$610,333 (\$305,167 Federal share) that Cerebral Palsy and Stavros processed for noncovered services.

The State agency agreed with GSA's findings. Accordingly, the State agency is undertaking an extensive review of its rules, regulations, policies, and procedures to determine what additional enhancements it could make to strengthen the integrity of the PCA program.

As we do with audit reports developed by non-Federal auditors, we have provided as an attachment a listing of the coded recommendations for your staff's use in working with the State through our stewardship program to resolve GSA's findings and recommendations.

If you have any questions about this review, please contact me or Curtis Roy, Audit Manager, at 617-565-2684. Please refer to report number A-OI-08-00001 in all correspondence.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PARTNERSHIP REVIEW OF
MEDICAID CLAIMS PROCESSED
BY CEREBRAL PALSY AND
STAVROS FOR PERSONAL CARE
ATTENDANT SERVICES
PROVIDED TO BENEFICIARIES
DURING INPATIENT STAYS**



Daniel R. Levinson
Inspector General

November 2008
A-01-08-00001

Office of Inspector General

<http://oig.hhs.gov>

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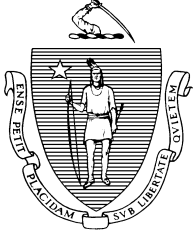
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The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

A. JOSEPH DeNUCCI
AUDITOR

TEL. (617) 727-6200

NO. 2008-1374-3S2

**INDEPENDENT STATE AUDITOR'S REPORT ON
CERTAIN ACTIVITIES OF THE
OFFICE OF MEDICAID AS ADMINISTERED BY
MASHEALTH IN THE PAYMENT OF CERTAIN
CLAIMS FOR PERSONAL CARE SERVICES
OCTOBER 1, 2004 TO SEPTEMBER 30, 2005**

**OFFICIAL AUDIT
REPORT
OCTOBER 28, 2008**

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INTRODUCTION**1**

In accordance with Chapter 118E of the Massachusetts General Laws, MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services for approximately one million low- and moderate-income individuals, couples, and families in Massachusetts. MassHealth annually pays in excess of \$6 billion on approximately 50 million claims to 30,000 providers, of which of 50% is federally funded.

Medicaid provides reimbursement for personal care services (PCS)¹ to help people with long-term disabilities live at home independently. MassHealth administers PCS through its Personal Care Attendant (PCA) Program, a MassHealth program under which personal care management (PCM) services, fiscal intermediary (FI) services, and PCA services are available to MassHealth members. Specifically, PCAs assist people (known in the program as “consumers”) with activities of daily living (e.g., taking medications, bathing, dressing, eating, using the toilet) and instrumental activities of daily living (e.g., preparing meals, doing housework, shopping, traveling to medical providers). In fiscal year 2005, MassHealth paid \$248 million on 746,000 claims related to PCS. This amount increased to \$302 million on 802,000 claims in fiscal year 2007.

New members of MassHealth and existing eligible members may apply for PCA services, after which MassHealth reviews the member’s statement of need for PCA services. If it is decided that PCA services may be needed, the member must contact a MassHealth-approved personal care (PC) agency. The PC agency is a public or private agency or entity under contract with EOHHS to provide personal care management (PCM) services in accordance with MassHealth regulations and the PCM services contract, or a public or private agency or entity that has been approved by EOHHS to provide transitional living services.² The PC agency meets with the member for an assessment and an evaluation on whether the member will be accepted and the extent of PCA services to be provided. Part of the evaluation is the PC agency’s determination of whether the consumer can manage the PCA program independently. If the PC agency determines that the consumer requires the assistance of a surrogate (a person who substitutes for consumers who are physically or cognitively unable to perform certain tasks), the consumer will appoint a surrogate who meets certain criteria.

Once accepted into the PCA program, consumers employ a PCA to assist them with the activities of daily living (ADLs) and with the instrumental activities of daily living (IADLs). The consumer or a surrogate is the sole party responsible to ensure that information submitted to the FI on the activity forms for each two-week pay period correctly identifies who provided the PCA services and the correct hours and dates during which the PCA services were provided.³ To provide PCM services, the PC agency must select a MassHealth-approved FI. The PC agency educates the consumer on the role of the FI, and

¹ 130 CMR 422.402: Personal Care Services are services provided to an eligible MassHealth member for the purpose of assisting the member to achieve independent living, including PCM services, PCA services, and fiscal intermediary services.

² 130 CMR 422.431 to 422.441

³ 130 CMR 422.420 (A) (3) & (4)

the FI performs numerous administrative tasks, including processing all claims for PCA services and verifying the mathematical accuracy of PCA activity forms. Moreover the FI, as an intermediary, accepts reimbursement from MassHealth for PCS for which the FI made payments to the PCA via the consumer.

The U.S. Department of Health and Human Services Office of Inspector General (HHS/OIG) issued a report on October 12, 2007 titled, "Review of Personal Care Services Claimed by the Center for Living and Working, Inc." EOHHS had a contract with the Center for Living and Working, Inc., (CLW) to provide FI services beginning in 1998 and PCS beginning in 2002. EOHHS terminated its FI contract with CLW in December 2005. HHS/OIG's report indicated that during the period October 1, 2003 through September 30, 2005, CLW did not always claim PCS in accordance with Medicaid rules and regulations. Errors were found that HHS/OIG attributed to CLW's lack of sufficient procedures to ensure that CLW claimed reimbursement for services in accordance with Medicaid rules and regulations. HHS/OIG found that reimbursements were paid for PCA-provided services on dates when the consumers were hospital inpatients and for PCA services that were either insufficiently documented or unauthorized. PCA services provided to a consumer while he or she is a resident of a nursing facility or other inpatient facility are not reimbursable under both state⁴ and federal⁵ regulations. Based on the audit's results, HHS/OIG estimated that CLW received overpayments of \$493,777, and recommended that the \$256,366 federal share be refunded.⁶

HHS/OIG has developed a Partnership Plan in an effort to provide broader coverage of the Medicaid Program, aimed at analyzing and controlling runaway Medicaid costs, by partnering with State Auditors to conduct joint reviews. HHS/OIG believes that the Partnership Plan approach will be a more effective and efficient use of limited audit resources by both the federal and state audit sectors. The Office of the State Auditor believes that this partnership will be a major benefit in effectively and efficiently auditing the Commonwealth's Medicaid program, which has a significant financial impact on both the federal and state budgets. Moreover, this cooperative audit effort has the potential to generate substantial cost savings at both levels. As part of the partnership, HHS/OIG extended its audit into MassHealth's reimbursement for PCA services while consumers are residents of nursing facilities or other inpatient facilities. HHS/OIG selected a sample of 200 periods of service (POS) for which claims were paid for PCA services performed at the time that the consumer could have been residing in a nursing facility or other inpatient facility. The HHS/OIG sample was given to the OSA for audit. (See Appendix.)

In accordance with Chapter 11, Section 12, of the General Laws, we conducted an audit of the HHS/OIG sample of claims. In the selection of its sample, HHS/OIG reviewed the PCS claimed by the two largest FI providers to MassHealth from October 1, 2004 through September 30, 2005 (federal fiscal year 2005). During this period, a total of \$169,585,212 was paid for 250,811 PCA service claims processed by the two FIs. Of this amount, HHS/OIG determined that \$3,311,605 was paid for 3,612 claims for PCA services that could have been provided while consumers were residents of nursing facilities or other inpatient facilities. The objective of our audit was to determine the quantity of hours and amount paid for PCA

⁴ 130 CMR 422.412 (D)

⁵ Section 1905(a)(24) of the Social Security Act

⁶ The federal funding participation rate from October 1, 2003 to June 30, 2004 was 52.95% and on July 1, 2004 assumed the current rate of 50%.

services performed during periods in which consumers were residents of nursing facilities or other inpatient facilities.

AUDIT RESULTS

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INADEQUATE INTERNAL CONTROLS AT MASSHEALTH HAS RESULTED IN ESTIMATED OVERPAYMENTS OF \$610,333 IN CLAIMS FOR PERSONAL CARE ATTENDANT SERVICES

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Our audit indicated that MassHealth's internal controls and procedures were inadequate to prevent or discover the payment of claims for PCA services performed while consumers are residents of nursing facilities or other inpatient facilities, resulting in overpayments as defined by applicable laws, rules, and regulations. We audited the sample of 200 POS provided by HHS/OIG and discovered that in 118 (59%) cases claims were paid for PCA services that were performed while the consumer was a resident of a nursing facility or other inpatient facility. The total amount paid in claims for PCA services in the sample was \$187,629, of which \$34,944 (18.6%) was overpaid. As a result of the inadequate internal controls and procedures and the high exception rate from the sample of 200, the OSA has initiated a more extensive audit that will include a review of documentation pertinent to the claims and providers. The expanded audit's objective will be to determine the cause and effect of these overpayments and to recommend improvements in MassHealth's internal controls and procedures relating to the PCA program.

HHS/OIG extrapolated the results of the OSA's audit of the sample to the entire population of POS for which claims were paid for PCA services performed when there was the potential that consumers were residents of a nursing facility or other inpatient facility. HHS/OIG thereby estimated that \$610,333 was overpaid by MassHealth for non-covered PCA services.

In response to the audit report, MassHealth indicated that it is undertaking an extensive review of its rules, regulations, policies and procedures to determine what additional enhancements could be made to strengthen the integrity of the PCA program. We are pleased that MassHealth has taken our audit results into consideration for corrective action.

APPENDIX

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SAMPLING METHODOLOGY, RESULTS, AND ESTIMATES

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INTRODUCTION

Background

In accordance with Chapter 118E of the Massachusetts General Laws, MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services for approximately one million low- and moderate-income individuals, couples, and families in Massachusetts. MassHealth annually pays in excess of \$6 billion on approximately 50 million claims to 30,000 providers, of which 50% is federally funded.

Medicaid provides reimbursement for personal care services (PCS) to help people with long-term disabilities live at home independently. PCS are services provided to eligible MassHealth members for the purpose of assisting the member to achieve independent living, including personal care management (PCM) services, personal care attendant (PCA) services, and fiscal intermediary (FI) services.⁷ Specifically, PCS assist members with activities of daily living (e.g., taking medications, bathing, dressing, eating, using the toilet) and instrumental activities of daily living (e.g., preparing meals, doing housework, shopping, traveling to medical providers). In fiscal year 2005, MassHealth paid \$248 million on 746,000 claims related to PCS. This amount increased to \$302 million on 802,000 claims in fiscal year 2007.

New members of MassHealth and existing eligible members may apply for PCA services, subject to the restrictions and limitations described in MassHealth regulations. MassHealth reviews the member's statement of need for PCA services and notifies the member of its decision. If it is decided that PCA services may be needed, the member must contact a MassHealth-approved PC agency, which will then meet with the member for an assessment and evaluation on whether the member will be accepted and the extent of PCA services to be provided. Part of the evaluation is the PC agency's determination of whether the consumer can manage the PCA program independently. If the PC agency determines that the consumer requires the assistance of a surrogate (a person who substitutes for consumers who are physically or cognitively unable to perform certain tasks), the consumer will appoint a surrogate who meets certain criteria. Each PC agency has a working relationship with a fiscal intermediary for all of the members it serves, and educates members in the role of the FI.

⁷ 130 CMR 422.402: Personal Care Services

When the PC agency accepts a member for PCA services, the member is then known in the program as a “consumer” and becomes the employer of his or her own PCA. This means that the consumer (or surrogate) becomes responsible for finding, hiring, training, and firing (if needed) his or her PCA. The consumer employs the PCA to assist him or her with the activities of daily living (ADLs) and with the instrumental activities of daily living (IADLs). The PCA is paid based on the number of 15-minute segments (units) that are performed providing ADLs and IADLs. The claims within this audit were paid at a rate of \$2.91 per unit for those occurring prior to January 2, 2005; \$3.00 per unit from then until July 3, 2005; and \$3.07 per unit thereafter. The premium rate for overtime and holidays is 150% of the base rate.

The consumer has to follow specific rules to make sure his or her PCA gets paid on time. The PC agency informs the consumer on how to get help with these duties, and the consumer or surrogate is responsible for complying with all applicable MassHealth regulations.⁸ It is the consumer’s responsibility to complete and sign activity forms and submit them to the FI. Additionally, the consumer is the sole party responsible for ensuring that information submitted on the activity forms for each pay period (two weeks) correctly identifies who provided the PCA services and the correct hours and dates during which the PCA services were provided.⁹ The billing and payment for the PCA services for the two-week pay period is considered one claim.

The PCA is not a provider to MassHealth, but an unlicensed independent contractor employed by the consumer. As such, the PCA is not regulated by MassHealth regulations, but is managed by the consumer or surrogate. The criteria set by MassHealth regulations are that services must be performed by a PCA who is: (a) not the spouse of the member, the parent of a minor member, including an adoptive parent, or any legally responsible relative; (b) not the member’s surrogate; (c) not the member’s foster parent; (d) legally authorized to work in the United States; (e) able to understand and carry out directions given by the member or the member’s surrogate; (f) willing to receive training and supervision in all PCA services from the member or the member’s surrogate; and (g) not receiving compensation from any other entity for that activity time performing PCA services except where such entity is nonprofit, does not receive funds from any state agency other

⁸ 130 CMR 422.420: PCA Program: Member Responsibilities

⁹ 130 CMR 422.420 (A) (3) & (4)

than MassHealth, and has a Board of Directors consisting of at least 51% members, family members, and/or siblings of members.¹⁰

The PC agency is a public or private agency or entity under contract with EOHHS to provide personal care management (PCM) services in accordance with MassHealth regulations and the PCM services contract; or a public or private agency or entity that has been approved by EOHHS to provide transitional living services.¹¹ Some of the PCM services provided are: (a) maintaining a communication system that is accessible to members on a 24-hour basis; (b) performing evaluations and reevaluations; (c) instructing the member in the rules, policies, and regulations of the PCA program; (d) providing functional skills training in the management of the PCA, personal health care maintenance, emergency management and interaction with the FI; (e) working with the member to establish a list of PCAs who can be contacted when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services; (f) reporting suspicion of fraud to the MassHealth agency in the format specified by the MassHealth agency and cooperating with any subsequent investigation; and (g) notifying the MassHealth agency if, in the opinion of the PC agency, the member's surrogate is not managing PCA tasks for the member in accordance with MassHealth regulations.¹²

To provide PCM services, the PC agency must select a MassHealth-approved FI. The FI performs numerous administrative tasks, including processing all claims for PCA services and verifying the mathematical accuracy of PCA activity forms that detail the hours of services performed by PCAs for a two-week period. Moreover, as an intermediary, the FI accepts reimbursement from MassHealth for PCS for which the FI made payments to the PCA via the consumer. Among other services performed by the FI are: (a) establishing a member services unit with staff trained to answer member telephone calls about activity forms, tax forms, and the functions of the fiscal intermediary; (b) establishing, in conjunction with the PC agency, systems to resolve member and PCA complaints in a timely fashion; (c) developing, using, and distributing standardized activity forms and schedules to document the use of PCAs and to meet the requirements for reimbursement; (d) issuing checks for PCAs with appropriate taxes withheld; and (e) reporting suspicion of fraud to the MassHealth

¹⁰ 130 CMR 422.411 (A) (1)

¹¹ 130 CMR 422.431 to 422.441

¹² 130 CMR 422.419 (A)

agency in the format requested by the MassHealth agency and cooperating with any subsequent investigation.¹³

The U.S. Department of Health and Human Services Office of Inspector General (HHS/OIG) issued a report on October 12, 2007 titled, “Review of Personal Care Services Claimed by the Center for Living and Working, Inc.” EOHHS had a contract with the Center for Living and Working, Inc., (CLW) to provide FI services beginning in 1998 and PCM services beginning in 2002. EOHHS terminated its FI contract with CLW in December 2005. HHS/OIG’s report revealed that during the period October 1, 2003 through September 30, 2005, CLW did not always claim PCS in accordance with Medicaid rules and regulations. Errors were found that HHS/OIG attributed to CLW’s lack of sufficient procedures to ensure that it claimed reimbursement for services in accordance with Medicaid rules and regulations. HHS/OIG found that reimbursements were paid for PCA-provided services on dates when the consumers were hospital inpatients and for PCA services that were either insufficiently documented or unauthorized. PCA services provided to a consumer while he or she is a resident of a nursing facility or other inpatient facility are not reimbursable under both state¹⁴ and federal regulations¹⁵. Based on the audit’s results, HHS/OIG estimated that CLW received overpayments of \$493,777 (\$256,366 federal share¹⁶). HHS/OIG recommended that CLW refund to the state agency the overpayment and strengthen procedures to ensure that it claims PCA services in accordance with Medicaid rules and regulations.

HHS/OIG has developed a Partnership Plan in an effort to provide broader coverage of the Medicaid Program, aimed at analyzing and controlling runaway Medicaid costs, by partnering with State Auditors to conduct joint reviews. The HHS/OIG believes that the Partnership Plan approach will be a more effective and efficient use of limited audit resources by both the federal and state audit sectors. The Office of the State Auditor believes that this partnership will be a major benefit in effectively and efficiently auditing the Commonwealth’s Medicaid program, which has a significant financial impact on both the federal and state budgets. This cooperative audit effort will generate substantial cost savings at both levels. As part of the partnership, HHS/OIG extended its

¹³ 130 CMR 422.419 (B)

¹⁴ 130 CMR 422.412 (D)

¹⁵ Section 1905(a)(24) of the Social Security Act authorizes payment for personal care services for a beneficiary “who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or an institution for mental disease. . . .”

¹⁶ The federal funding participation rate from October 1, 2003 to June 30, 2004 was 52.95% and on July 1, 2004 assumed the current rate of 50%.

audit into MassHealth's reimbursement for PCA services while consumers are residents of nursing facilities or other inpatient facilities. As will be explained in greater detail in the Audit Scope, Objectives, and Methodology section of this report, HHS/OIG selected a sample of 200 periods of service (POS) during which claims were paid for PCA services performed when consumers could have been residents of nursing facilities or other inpatient facilities. From each of the two largest FI providers in the Commonwealth 100 POS were selected. The FIs billed the claims for PCS services to MassHealth, the Massachusetts Medicaid Management Information System (MMIS) processed them, and payments to the PCAs were issued by the FIs. The HHS/OIG sample was given to the OSA to be audited.

Audit Scope, Objectives, and Methodology

The OSA and HHS/OIG have established a Partnership Plan in an effort to provide broader coverage of the Medicaid Program and to provide for more effective and efficient use of scarce audit resources by both the federal and state audit sectors. In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, we conducted an audit of a sample of 200 POS, that was selected and provided to us by HHS/OIG (see Appendix), which included claims paid for PCA services performed at a time when the consumers could have been residents in nursing facilities or other inpatient facilities. Our audit was conducted in accordance with applicable generally accepted government auditing standards. Our objective was to determine whether claims were paid for PCA services rendered while consumers were residents of nursing facilities or other inpatient facilities and, if they were, to quantify the number of hours and the amount paid on these claims.

In the selection of its sample, HHS/OIG reviewed the PCS claimed by the two largest FI providers to MassHealth from October 1, 2004 through September 30, 2005 (federal fiscal year 2005). During this period, a total of \$169,585,212 was paid for 250,811 PCA service claims processed by these two FIs. Of this amount, HHS/OIG determined that \$3,311,605 was paid for 3,612 claims for PCA services that could have been provided while consumers were residents in nursing facilities or other inpatient facilities. HHS/OIG limited consideration of the FIs' internal control structure to those internal controls concerning PCA claims processing because the objective of its review did not require an understanding or assessment of the complete internal control structure. Further, HHS/OIG concluded that its review of the internal control structure could be conducted more efficiently by substantive testing.

HHS/OIG then compiled a record from the Center for Medicare and Medicaid Services (CMS) Medicaid Statistical Information System for each of the FI provider's claims for PCA services that may have been provided during an inpatient stay, from October 1, 2004 through September 30, 2005. From that record a random sample of 100 POS from federal fiscal year 2005 was selected for each provider and forwarded to the OSA. It was HHS/OIG's objective to use the random sample to estimate the total dollar value of inappropriately paid PCA claims for services provided during inpatient stays for the total fiscal year.

The OSA delivered to the two FIs the sample of 100 POS processed by them and requested that they provide us with the applicable activity forms that identify who provided the PCA services and the hours and dates that the PCA services were provided for the period for which the claims were processed. We visited the FIs at their places of business, interviewed management regarding procedures, and collected the activity forms for our review. Utilizing the Medicaid Management Information System (MMIS) and the data warehouse, we matched dates of PCA services that corresponded with the same days during which the consumers were residents of a nursing facility or other inpatient facility (dates of admission and discharge were excluded). The OSA then quantified the number of hours and the amount paid on all inappropriately paid claims.

The OSA conducted meetings with the FIs and with various management and personnel of MassHealth and EOHHS, and we reviewed applicable state and federal laws, rules, and regulations, as well as applicable MassHealth and EOHHS policies and procedures.

AUDIT RESULTS

INADEQUATE INTERNAL CONTROLS AT MASSHEALTH HAS RESULTED IN ESTIMATED OVERPAYMENTS OF \$610,333 IN CLAIMS FOR PERSONAL CARE ATTENDANT SERVICES

Our audit found that MassHealth's internal controls and procedures are inadequate to prevent or detect overpayments resulting from the payment of claims for Personal Care Attendant (PCA) services performed while consumers are residents of nursing facilities or other inpatient facilities. We audited a sample of 200 periods of service (POS) provided by the United States Department of Health and Human Services' Office of Inspector General (HHS/OIG) and discovered that in 118 (59%) cases claims were paid for PCA services that were performed while the consumer was a resident of a nursing facility or other inpatient facility. The total amount paid in claims for PCA services in the sample was \$187,629, of which \$34,944 (18.6%) was overpaid and potentially fraudulent. MassHealth and Executive Office of Health and Human Services (EOHHS) management agreed that the claims were for non-covered services and overpaid. They also stated that they were unaware that payments had been made for PCA services while consumers were residents of nursing facilities or other inpatient facilities. The 130 Code of Massachusetts Regulations (CMR) 422.412, Non-Covered Services, states, in part:

MassHealth does not cover any of the following as part of the PCA program or the transitional living program: . . . (D) PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility;

MassHealth and EOHHS management acknowledged that internal controls were inadequate to prevent these payments, and indicated that a prepayment edit in the Medicaid Management Information System (MMIS) designed to deny payment for PCA services that were performed while a consumer was a resident of a nursing facility or other inpatient facility would not be effective. They also noted that laws and regulations require timely payment to PCAs for services rendered, and that payments are currently made before any evidence of a consumer's hospital or nursing facility residence is entered in MMIS. They therefore concluded that MassHealth's only remaining option was to "pay and chase" (i.e., post payment reviews to identify overpayments and seek refunds of funds paid) the claims. Management further noted the following:

The consumer, as the employer of PCA services, is ultimately responsible; there is no one person/party on the MassHealth side that is responsible.

As a result, the only internal control over payments for services resides in MassHealth's trust in consumers' and surrogates' veracity. Consumers and their surrogates are the sole parties responsible for ensuring that the information submitted to the FI on the activity forms for each two-week pay period correctly identifies who provided the PCA services and the correct hours and dates that the PCA services were provided. The 130 CMR 422.420, PCA Program Member Responsibilities, states, in part:

As a condition of receiving MassHealth PCA services, the member must:

- (3) complete and sign activity forms and submit them to the fiscal intermediary in accordance with the instructions provided and time frame specified by the fiscal intermediary;*
- (4) ensure that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services, and the correct hours and dates that the PCA services were provided; . . .*
- (12) notify the personal care agency when there is a change in the member's medical condition or living situation that may require an adjustment in the number of day/evening hours per week or night hours per night authorized by the MassHealth agency; . . .*
- (20) comply with all applicable MassHealth regulations.*

We reviewed all of the activity forms for each POS in the audit sample and data in MMIS that confirmed that the claims for PCA services performed as indicated on these forms were paid. Additionally, we researched in MMIS and its data warehouse all claims paid for services provided to the consumers during the applicable POS for hospital and nursing facilities. We found that PCA services were performed for consumers when they were either a hospital inpatient or a resident of a nursing facility.

Our review determined that 118 of the 200 POS paid claims in our sample, or 59%, were claims made for non-covered services where a consumer was in a nursing facility or other inpatient facility. The paid claims in our sample were \$187,629, of which \$34,944, or 18.6%, was paid for non-covered services. The average exception in the sample was \$296.13. There was a higher incidence of consumers being hospital inpatients than residents of nursing facilities. However, those in nursing facilities experienced a longer period of residence than those in hospitals. As a result, the percentage exception for consumers who were in nursing facilities was 46.7% versus a

percentage exception of 62.7% for consumers in hospitals. The following tables summarize the results of our review of activity forms and consumers' residency.

Results of OSA Audit of Sample

	Totals	Inpatient Hospital	Resident in Nursing Facility	In Both Facilities
Quantities				
Audit Sample Residency during POS	200	153	45	2
PCA Services Claimed and Paid for Non-Covered Services	118	96	21	1
Percentage Exceptions	59.0%	62.7%	46.7%	50.0%
Amounts				
PCA Services Claimed and Paid during Total POS in Sample	\$187,629	\$148,073	\$38,375	\$1,181
PCA Services Claimed and Paid for Non-Covered Services	\$34,944	\$23,164	\$11,442	\$338
Percentage Exceptions	18.6%	15.6%	29.8%	28.6%
Average Exception	\$296.13	\$241.29	\$544.88	\$337.70

HHS/OIG extrapolated the results of the OSA's audit of the sample to the entire population of POS for which claims were paid for PCA services performed when there was the potential that the consumer was a resident of a nursing facility or other inpatient facility. HHS/OIG thereby estimated that \$610,333 was overpaid by MassHealth for non-covered PCA services.

(See Appendix.)

As a result of the large exception rate and the lack of internal controls in MassHealth's administration of the PCA program, the OSA has initiated a more extensive audit of the sample of overpaid claims with the objective of determining the cause and effect of the overpayments and to make recommendations for their prevention and detection. Specifically, the OSA will determine whether all parties to the claim (the consumer, PCA, PC agency, and FI) were in compliance with applicable laws, rules, and regulations and whether MassHealth has the proper internal controls in place to prevent fraud and abuse and ensure compliance. We will research in our expanded-scope audit whether the anticipation of imminent homecomings and shorter stay caused the percentage of exceptions to be higher for consumers who were hospital inpatients. Also, we will attempt to determine why there is a substantially different ratio between FIs of consumers being hospital inpatients to those that are residents of nursing facilities, as well as the percentage of exceptions.

Recommendation

Based on the results of our audit, MassHealth should strengthen its internal controls and oversight over payments for PCA services to ensure that it is not paying for non-covered services, including those provided while consumers are residents of nursing facilities or other inpatient facilities. We recommend that MassHealth:

1. Conduct an extensive investigation into each of the paid claims determined in the audit to not be in compliance with applicable laws, rules, and regulations to determine (a) whether fraud occurred and (b) which policies, procedures, and internal controls need to be amended to prevent fraud and abuse and ensure compliance.
2. Consider expanding the obligations of the PC agencies' management role to include frequent periodic checks to verify that the PCAs are actually performing services for the hours and on the days claimed in the activity forms.
3. Develop edits within MMIS that will suspend payment for PCA services when there is any evidence that the consumer is a resident of a nursing facility or other inpatient facility, and expand these edits to include all non-covered services as indicated in 130 CMR 422.412.
4. Establish regular audits of PCS by the internal audit department with the intent to detect, prevent, and deter fraud and abuse. Conduct an audit of all payments for PCA services during state fiscal years 2006-2008 and identify overpayments for non-covered services.
5. Seek and collect refund of the estimated \$610,333 in claims paid for non-covered services.
6. Notify all consumers, surrogates and PCAs by letter of the serious nature of making a false claim and the potential penalty to be borne by the offending party.
7. Consider establishing rules and regulations for PCAs that clearly delineate their obligations relative to the veracity of the activity forms in addition to the criteria indicated in 130 CMR 422.411 (A) (1).
8. Refer all instances of potential consumer fraud and potential provider fraud to the Office of the State Auditor's Bureau of Special Investigations and the Medicaid Fraud Control Unit in the Office of the Attorney General.

Auditee's Response

The MassHealth Personal Care Attendant (PCA) program is a critical component of MassHealth's community long term care delivery system. The program is a core service that empowers and supports people with disabilities and elders (Consumers) to live with dignity and independence. By design, the program is constructed as a consumer

directed program. Consumers are the employers of their PCAs, and are supported by MassHealth through contracted services delivered by Personal Care Management Agencies (PCM) and Fiscal Intermediaries (FI). Massachusetts' program is nationally recognized for the maturity of its program design including, specifically, the extent of the employer-related supports provided to Consumers. As the Commonwealth continues to maximize the extent to which people with disabilities and elders are able to live successfully in their homes and communities, MassHealth will continue to work diligently to improve the capacity and quality of long term care programs, including ensuring that the PCA program includes sufficient and appropriate mechanisms for program integrity.

MassHealth has implemented a variety of internal controls within the PCA program. These controls are designed to ensure that members have timely access to medically necessary PCA services, that members and their surrogates are provided with the information necessary to successfully manage the PCA program, and that we maximize the efficient use of program resources by minimizing the possibilities for fraud, waste, and abuse. Although we strive for complete prevention of fraud and abuse in this program, we are encouraged by the OSA's findings in this audit that less than 0.36% of the total PCA program spending was subject to the type of potential abuse identified in your report.

Because of the unique design of the PCA program, many of the typical methods for maintaining program integrity used in the administration of other MassHealth services are not appropriate or available for PCA. Based on OSA's findings, however, MassHealth is undertaking an extensive review of its rules, regulations, policies, and procedures to determine what additional enhancements could be made to strengthen the integrity of the MassHealth PCA program.

We would like to take this opportunity to respond to OSA's recommendations.

Recommendation #1

MassHealth will continue to work closely with the Office of the State Auditor's Bureau of Special Investigations (BSI) regarding the PCA program. MassHealth and BSI jointly developed policies and procedures and a referral form specific to reporting suspicion of PCA program fraud; PCM Agencies and Fiscal Intermediaries are required to use this form when reporting suspicion of PCA program fraud. MassHealth and BSI meet at least twice per year to review reported cases. In addition, MassHealth has included BSI in statewide trainings of PCM Agencies and FIs to educate them on their responsibilities in reporting cases of suspected fraud. MassHealth refers all reports to BSI and logs and tracks all referrals. MassHealth has referred over 1,400 cases of suspicion of fraud to BSI in the past 10 years. MassHealth will continue to refer cases, including the specific cases identified by OSA during its audit to BSI for investigation to determine whether or not fraud occurred.

MassHealth is reviewing its current policies, procedures, and internal controls to determine if there is additional action that MassHealth, PCM Agencies, or Fiscal Intermediaries can take to detect or prevent fraud and abuse.

Recommendation #2

PCM Agencies are responsible for educating MassHealth members as to their responsibilities as participants in the MassHealth PCA program, and as employers of their PCAs. This education and skills training includes informing a Consumer that the

PCAs they employ cannot work for them while the Consumer is an inpatient of a facility, and that the Consumer and PCA must certify the appropriateness of each activity form submitted.

MassHealth will continue to evaluate the roles of its contractors to determine what additional actions PCM Agencies and FIs could take to ensure that Consumers are clearly instructed and reminded of their responsibilities to ensure PCAs are employed in accordance with applicable PCA rules and regulations.

Recommendation #3

PCAs must be paid in a timely manner and, as PCA claims are generally received and paid well in advance of claims for facility services, it is not possible for MassHealth to develop edits that will suspend payment for PCA services prior to payment. MassHealth is, however, working to develop a schedule of post-payment reviews of PCA. MassHealth will take appropriate action to follow up on any overlaps in services identified in the post-payment reviews, including referral to BSI for further investigation as appropriate.

Recommendation #4

MassHealth is developing a number of algorithms to detect anomalies in our PCA program, and is in the process of conducting a review of all potential overpayments made during 2006-2008 for PCA services provided while Consumers were in facilities. MassHealth will follow up on its findings, including submitting referrals to BSI as appropriate.

Recommendation #5

Implementation of this recommendation is contingent upon BSI completing investigations of the 18 cases identified in the OSA audit.

Recommendation #6

Current signature language appearing on all activity forms was developed in conjunction with BSI and requires Consumers and PCAs to certify, under the pain and penalty of perjury, that services were provided during the time identified on the form. MassHealth is, however, working with its PCM Agencies and FIs to further strengthen language on standardized forms, including the activity forms, the Service Agreement form, the Consumer Agreement form, and the PCA Signature form. MassHealth has published and distributed to each PCA Consumer the MassHealth PCA Consumer Handbook, which includes language related to a Consumer's responsibility not to bill for PCA services while the Consumer is in a facility.

Recommendation #7

Please see Recommendations 2 and 6 above. In addition, MassHealth will add language to the PCA Signature Form reminding PCAs that they cannot receive payment for PCA services provided while a Consumer is an inpatient of a facility.

Recommendation #8

See Recommendation 1 above. MassHealth works closely with BSI and will continue to do so. Any suspicion of provider fraud is and will be reported to MFCU.

As indicated above, as a result of the issue identified by OSA, MassHealth is conducting a thorough review of its rules, regulations, policies, and procedures and will determine what additional enhancements could be made to strengthen the integrity of the MassHealth PCA program.

Auditor's Reply

We are pleased that MassHealth has taken our audit results into consideration and has either taken corrective action, will take corrective action, or will further evaluate the feasibility of implementing the recommendations in our report. With regard to MassHealth's statement that they are encouraged that our findings represented less than 0.36% of the total PCA program, please note that our audit was limited to the sample supplied to us by HHS/OIG, and is not a comprehensive audit of the program. The total amount of overpayments for federal fiscal year 2005 were estimated to be \$610,333 based on our sample, which is a substantial sum that should not be dismissed. Further, the continued growth and increased cost of the program, as well as three additional years of program activity, significantly increases this overpayment estimate.

We agree with MassHealth's response that it may not be feasible to suspend payment via edits for PCA services on a timely basis. Nevertheless, such edits could be a useful tool in quickly identifying claims subject to post-payment review.

We acknowledge MassHealth's ongoing work with the Office of the State Auditor's Bureau of Special Investigations (BSI), and we encourage an internal investigation of the claims. However, we do not agree that MassHealth's investigation and recovery of payments made for non-covered services should be contingent on a BSI investigation of the claims. If the claims were paid for non-covered services, refunds should be sought.

The audit identified a substantial number of questionable paid claims that, when combined with internal control weaknesses, supports our conclusion that the risks of questionable and potentially fraudulent claims being paid is significant. Therefore, MassHealth should continue to take the necessary corrective actions to improve its internal controls over claims processing for the PCA program.

As noted in our report, we are currently conducting an expanded-scope audit of the PCA program that will include a review of all pertinent documentation. The objectives of the expanded audit will be to determine the cause and effect of these overpayments and to make recommendations for improving MassHealth's internal controls and procedures in the PCA program.

APPENDIX

SAMPLING METHODOLOGY, RESULTS, AND ESTIMATES

OBJECTIVE

The objective of the audit was to determine whether the two Fiscal Intermediaries (FI) were processing claims for personal care services while the beneficiaries were inpatients.

POPULATION

The populations consisted of 2,198 and 1,414 paid claims totaling \$1,955,526 and \$1,356,079 that FI #1 and FI #2 processed from October 1, 2004 through September 30, 2005. The 3,612 total personal care attendant claims have dates of service that overlap inpatient dates of service.

SAMPLE DESIGN

The two simple random samples were designed to select 100 paid claims from each FI that were processed with dates of services from October 1, 2004 through September 30, 2005.

SAMPLE SIZE

FI #1 and FI #2 samples consisted of 100 paid claims each totaling \$14,825 and \$20,119, respectively.

APPENDIX (CONTINUED)

SAMPLING METHODOLOGY, RESULTS AND ESTIMATES

SAMPLE RESULTS

Federal Fiscal Year 2005	Sample Size	Value of Sample	Number of Errors	Value of Errors
FI #1	100	\$1,955,526	54	\$14,825
FI #2	100	\$1,356,079	64	\$20,119

ESTIMATES OF OVERPAYMENTS

	Projected Value of Erroneous Claims
FI #1 Point Estimate	\$325,852
90-Percent Confidence Level	
Lower Limit	\$243,676
Upper Limit	\$408,029
FI #2 Point Estimate	\$284,481
90-Percent Confidence Level	
Lower Limit	\$210,548
Upper Limit	\$358,414

Summary of Recommendations
Contained in OSA Report

Recommendation Codes	Page	Federal Share Amount	Resolution Agency	Sequence	Recommendations
21290110	10	N/A	CMS	1	Conduct an extensive investigation into each of the paid claims determined in the audit to not be in compliance with applicable laws, rules, and regulations to determine (a) whether fraud occurred and (b) which policies, procedures, and internal controls need to be amended to prevent fraud and abuse and ensure compliance.
29992610	10	N/A	CMS	2	Consider expanding the obligations of the PC agencies' management role to include frequent periodic checks to verify that the PCAs are actually performing services for the hours and on the days claimed in the activity forms.
20291910	10	N/A	CMS	3	Develop edits within MMIS that will suspend payment for PCA services when there is any evidence that the consumer is a resident of a nursing facility or other inpatient facility, and expand these edits to include all non-covered services as indicated in 130 CMR 422.412.
21290110	10	N/A	CMS	4	Establish regular audits of PCS by the internal audit department with the intent to detect, prevent, and deter fraud and abuse. Conduct an audit of all payments for PCA services during state fiscal years 2006-2008 and identify overpayments for non-covered services.

32291601	10	\$305,167	CMS	5	Seek and collect refund of the estimated \$610,333 in claims paid for non-covered services.
21292310	10	N/A	CMS	6	Notify all consumers, surrogates and PCAs by letter of the serious nature of making a false claim and the potential penalty to be borne by the offending party.
29991910	10	N/A	CMS	7	Consider establishing rules and regulations for PCAs that clearly delineate their obligations relative to the veracity of the activity forms in addition to the criteria indicated in 130 CMR 422.411.
21292310	10	N/A	CMS	8	Refer all instances of potential consumer fraud and potential provider fraud to the Office of the State Auditor's Bureau of Special Investigations and the Medicaid Fraud Control Unit in the Office of the Attorney General.