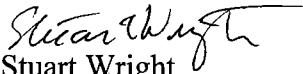




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**TO:** David Frank  
Director of Medicaid Integrity Group  
Centers for Medicare & Medicaid Services

**FROM:**   
Stuart Wright  
Deputy Inspector General  
for Evaluation and Inspections

**SUBJECT:** Memorandum Report: "Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day," OEI-07-06-00621

This memorandum report provides the results of our analysis of the total number of hours billed for Medicaid-funded personal care services (PCS) in five States. Our objective was to further examine the extent to which PCS claims may be vulnerable to payment errors because of billing practices identified in a related evaluation. To perform our analysis, we used claims data collected for the Office of Inspector General (OIG) evaluation entitled "Payments Made in Error for Personal Care Services During Institutional Stays" (OEI-07-06-00620).

That evaluation determined the extent to which five States made Medicaid payments for PCS during periods of beneficiary institutionalization and was focused on beneficiaries with overlapping institutional and PCS claims. We identified some payments made in error because the number of PCS hours paid exceeded 24 hours per day. We therefore examined all paid PCS claims in the five States for those claims that included billing for units of services in excess of 24 hours per day, irrespective of other services that beneficiaries were receiving (e.g., institutional services).

We found 871 paid claims for PCS that were billed in excess of 24 hours per day in four of the five States, indicating possible payment errors that may not have been identified by existing State controls. In addition, we found many other claims for PCS that totaled or nearly totaled 24 hours per day.

## **BACKGROUND**

### **Medicaid Personal Care Services**

PCS are provided to the elderly, individuals with disabilities, and individuals with chronic or temporary conditions to assist them 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.<sup>1</sup>

States may provide PCS to eligible Medicaid beneficiaries through State plan and waiver programs, or through a combination of both. States that provide PCS through a State plan program must conform to the general Medicaid program requirements outlined in section 1902 of the Social Security Act. States have also provided PCS through section 1115 demonstrations and through section 1915(c) Home and Community-Based Services waiver programs.

State Medicaid programs are providing personal care and other home- and community-based services to an ever-increasing number of Medicaid beneficiaries in efforts to contain Medicaid spending and avoid beneficiary institutionalization. State and Federal Medicaid expenditures for PCS reached \$9.4 billion in 2005, an increase of 56 percent over 3 years.<sup>2</sup> The Congressional Budget Office (CBO) estimates that by 2015, States with about a quarter of Medicaid enrollment will use provisions of the Deficit Reduction Act of 2005 to extend personal care and other home- and community-based services to an additional 120,000 beneficiaries.<sup>3</sup>

Section 1902(a)(30)(A) of the Social Security Act and 42 CFR 447.200 require States to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care standards. Billing practices that may result in undetected overpayments for PCS are not consistent with these requirements and represent a potential source of vulnerability for payment errors.

## **METHODOLOGY**

For our evaluation entitled “Payments Made in Error for Personal Care Services During Institutional Stays” (OEI-07-06-00620), we collected Medicaid claims data from five States for PCS provided from October 1 through December 31, 2005. The five States are Minnesota, New Mexico, North Carolina, Texas, and Washington. We used these data to conduct this analysis.

### **Identification of Paid Personal Care Services Claims in Excess of 24 Hours per Day**

To identify claims in which providers billed Medicaid for more than 24 hours of PCS in a day, we first determined the number of days covered by each claim. We then multiplied the maximum number of billing units possible in a 24-hour period by the number of days

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<sup>1</sup> The “State Medicaid Manual,” Pub. No. 45, § 4480(C). Available online at [http://www.cms.hhs.gov/manuals/downloads/P45\\_04.zip](http://www.cms.hhs.gov/manuals/downloads/P45_04.zip). Accessed on January 16, 2008.

<sup>2</sup> Centers for Medicare & Medicaid Services (CMS), CMS-64 summary data for 2002 and 2005.

<sup>3</sup> CBO memorandum, “Additional Information on CBO’s Estimate for the Medicaid Provisions in the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005.” January 31, 2006. Available online at <http://www.cbo.gov/ftpdocs/70xx/doc7033/s1932medic.pdf>. Accessed April 16, 2008.

covered by each claim. If a claim covered 3 days and the services were billed in 15-minute units, the maximum number of units possible during that timeframe would be 288 (96 units per day times 3 days). More than 288 units paid through this claim would result in more than 24 hours of services per day. If a beneficiary had multiple claims for PCS with the same date(s) of service, we combined the units billed on all claims with the same date(s) to determine the total number of units billed.<sup>4</sup> We then identified all claims for which the total hours of services paid exceeded the maximum number of hours possible for the day(s) included in the range of days covered by the claim. PCS claims are generally billed in date ranges. Although some States require that PCS be provided on every day included in the date range, other States allow the date ranges to include days on which no services were provided. Because of this practice, our analysis provides a conservative estimate of claims paid in error in the five States studied.

### **Limitations**

This analysis was conducted as part of an effort to identify future OIG work. Therefore, we used available data rather than requesting updated or additional data from the States or the Centers for Medicare & Medicaid Services. The data we used did not include per-unit payment rates for PCS. Without this information, we are unable to determine the expenditures for services billed in excess of 24 hours per day.

Beneficiaries with serious medical conditions or exceptional needs may require many hours of PCS per day and/or multiple PCS attendants, resulting in more than 24 hours of services per day. Therefore, it is possible that claims billing for services in excess of 24 hours per day were paid appropriately. However, these situations would be rare, and without conducting further review, we cannot determine the accuracy of these payments.

### **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.

## **RESULTS**

### **In One Quarter, State Medicaid Programs in the Five States Reviewed Paid 871 Claims for PCS That Billed in Excess of 24 Hours per Day**

In four of the five States, Medicaid paid 871 PCS claims that billed in excess of 24 hours of services per day from October 1 through December 31, 2005. We did not have sufficient information to determine how much of the \$873,132 associated with these claims was for services billed in excess of 24 hours of services per day. However, 22 percent of the total hours paid for these claims were in excess of the maximum number of hours possible during the period covered by the claim. Although it is possible that these claims were paid appropriately, without conducting further review, we cannot determine the accuracy of these payments. Table 1 provides an overview of the claims

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<sup>4</sup> To ensure the accuracy of our analysis, we limited the analysis to claims for PCS billed in units of 15 minutes or 1 hour. Claims billed in units of 1 or more days were excluded from our analysis. Some State Medicaid programs pay PCS in daily or monthly units, but the use of such units does not necessarily mean that PCS were provided every hour of that day or month. Rather, the provider is paid a fee for services needed on the day or in the month billed, regardless of the hours of service that were provided.

identified and Medicaid payments for PCS claims that billed in excess of 24 hours per day.

Table 1: Medicaid Claims for PCS That Billed in Excess of 24 Hours per Day

State	PCS Claims for Services From October 1 Through December 31, 2005, in Five States				
	Number of Claims	Amount Paid	Total Paid Hours for These Claims	Hours in Excess of Maximum Possible	Percentage of Hours in Excess of Maximum
Minnesota	273	\$507,129	35,751	4,431	13%
New Mexico	173	\$115,795	6,244	1,852	30%
North Carolina	0	0	0	0	0
Texas	263	\$190,620	18,327	7,360	40%
Washington	162	\$59,588	6,940	1,420	20%
<b>Total</b>	<b>871</b>	<b>\$873,132</b>	<b>67,262</b>	<b>15,063</b>	<b>22%</b>

Source: OIG analysis of Medicaid Management Information System claims data, 2008.

To further explore potential vulnerabilities present in Medicaid PCS claims, we also examined claims that billed high hours per day but did not exceed the maximum possible hours. In the five States, Medicaid paid 2,324 PCS claims that billed between 16 and 24 hours of services per day from October 1 through December 31, 2005. These claims represent an additional \$3,014,389 in potentially inappropriate payments. Table 2 provides an overview of the claims identified and Medicaid payments for PCS claims that billed between 16 and 24 hours per day.

Table 2: Medicaid Claims for PCS That Billed Between 16 and 24 Hours per Day

State	PCS Claims for Services From October 1 Through December 31, 2005, in Five States	
	Number of Claims	Amount Paid
Minnesota	1,767	\$2,708,499
New Mexico	160	\$96,162
North Carolina	36	\$6,219
Texas	83	\$49,874
Washington	278	\$153,635
<b>Total</b>	<b>2,324</b>	<b>\$3,014,389</b>

Source: OIG analysis of Medicaid Management Information System claims data, 2008.

### Some States' Billing Practices Create Vulnerabilities

The Minnesota, Texas, and Washington Medicaid programs allowed providers to bill for PCS in date ranges that included days on which no services were provided, a practice that makes it difficult to identify the number of PCS hours billed on any given day in a date range. This practice also makes it difficult to identify PCS claims that billed in excess of 24 hours per day. For example, if the date range for a claim covers 4 days, up to 384 15-minute units could be appropriate. However, if the beneficiary received services on only 2 of those days, a maximum of only 192 units would be appropriate. If the State

allowed the provider to submit a claim including 2 days on which no services were provided, any number of units up to 384 could appear appropriate, when in reality no more than 192 units could be appropriate. Our evaluation of Medicaid payments for PCS during periods of beneficiary institutionalization found that allowing providers to bill for PCS in date ranges that could include institutional stays may render State controls ineffective. One State was already in the process of implementing changes requiring providers to submit claims with exact dates of services to ensure that its payment edits would work in future institutional stays. Such a change could also help to prevent payments for PCS claims billed in excess of 24 hours per day and identify “high hours” claims that may need further evaluation.

## **CONCLUSION**

The OIG report entitled “Payments Made in Error for Personal Care Services During Institutional Stays” (OEI-07-06-00620) focused on Medicaid payments for PCS provided during periods of institutionalization and noted the vulnerabilities associated with PCS billed in date ranges that include days on which no services were provided. The report recommended that CMS (1) enforce existing Federal Medicaid policies that prohibit Medicaid reimbursement for PCS provided over a range of dates if the range includes days on which the beneficiary was institutionalized and (2) work with States to reduce the erroneous Medicaid payments for PCS during institutional stays. In light of the additional analysis presented in this memorandum report, CMS may also want to consider providing States with information regarding the vulnerability associated with claims for PCS billed in excess of 24 hours per day and billing practices that permit providers to submit PCS claims in date ranges that include days on which no services were provided.

This memorandum report is being issued directly in final form because it contains no recommendations. We will forward the Medicaid PCS claims we identified that billed high hours per day under separate cover. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-07-06-00621 in all correspondence.

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