

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MISSOURI CLAIMED FEDERAL
REIMBURSEMENT FOR \$3.4 MILLION
IN PAYMENTS TO HEALTH HOME
PROVIDERS THAT DID NOT MEET
MEDICAID REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: August 2021

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Why OIG Did This Audit

The Medicaid “health home” option allows States to create programs that provide care coordination and care management for beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model in which providers work together to coordinate and manage beneficiaries’ care at a reasonable cost.

For Federal fiscal year 2019, States claimed Federal Medicaid reimbursement for health home services totaling \$611 million (\$408 million Federal share). Missouri’s program accounted for 4 percent of the Federal share.

Our objective was to determine whether Missouri’s claims for Medicaid reimbursement for payments made to health home providers complied with Federal and State requirements.

How OIG Did This Audit

Our audit covered 1.3 million payments made to health home providers for services paid during calendar years 2016 through 2018, totaling approximately \$98 million (\$62 million Federal share). We reviewed a stratified random sample of 150 payments. For each sampled payment, we reviewed the health home providers’ documentation and beneficiaries’ medical records or other documentation.

Missouri Claimed Federal Reimbursement for \$3.4 Million in Payments to Health Home Providers That Did Not Meet Medicaid Requirements

What OIG Found

Missouri claimed Federal Medicaid reimbursement for some payments made to health home providers that did not comply with Federal and State requirements. Missouri improperly claimed Federal Medicaid reimbursement for 14 of 150 payments. These 14 improper payments primarily involved deficiencies in documentation. Specifically, Missouri’s health home providers did not always document core services, but all other requirements were met.

The improper payments occurred because Missouri did not adequately monitor providers for compliance with Federal and State requirements regarding the maintenance of medical records that documented the health home services that the providers furnished to beneficiaries.

On the basis of our sample results, we estimated that Missouri improperly claimed at least \$3.4 million in Federal Medicaid reimbursement for payments made to health home providers.

What OIG Recommends and Missouri Comments

We recommend that Missouri refund \$3.4 million to the Federal Government and improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received payments.

Missouri addressed our second recommendation by concurring that the health home programs should be monitored. Missouri also described its monitoring and training activities for health home providers. Missouri did not agree with our first recommendation and disagreed with our findings. Missouri said that the rejected sampled payments complied with the State plan and Federal documentation requirements and that these payments did not violate State policy. Missouri also said that we had not adequately explained our basis for rejecting these payments, and added that extrapolation was inappropriate in this audit. After reviewing Missouri’s comments and the additional documentation it provided, we maintain that our findings and recommendations are valid. Federal Medicaid requirements state that Federal reimbursement is available only for allowable actual expenditures with adequate supporting documentation. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Medicaid “health home” option allows States to create programs that provide care coordination and care management for Medicaid beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model based on the idea that several providers can work together to coordinate and manage beneficiaries’ care and, in doing so, provide quality care at a reasonable cost. As of April 2020, Missouri was among 20 States and the District of Columbia to implement Medicaid health home programs. For Federal fiscal year 2019, States claimed Federal Medicaid reimbursement for health home services totaling approximately \$611 million (\$408 million Federal share). Missouri accounted for approximately 4 percent of the Federal share.

This audit is part of a series of audits to determine whether selected States complied with Federal and State requirements when claiming Federal Medicaid reimbursement for payments made to health home providers. We reviewed payments made to Missouri’s Medicaid health home providers for services furnished to enrolled beneficiaries under the State’s health home programs. Appendix B contains a list of related Office of Inspector General (OIG) reports.

OBJECTIVE

Our objective was to determine whether the Missouri Department of Social Services’ (State agency’s) claims for Medicaid reimbursement for payments made to health home providers complied with Federal and State requirements.

BACKGROUND

Medicaid Health Home Services

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Missouri, the State agency administers the Medicaid program. During our audit period (January 2016 through December 2018), Missouri’s Federal Medicaid Assistance Percentage (FMAP, or Federal share) ranged from 63.28 percent to 65.40 percent.

Effective January 2011, section 1945 of the Social Security Act (the Act) was amended to include an option for States to establish a health home program through a Medicaid State plan amendment (SPA) approved by CMS. In practice, States can submit, and receive CMS approval for, one or more SPAs to establish a health home program through a care management service model in which all parties involved in an enrolled beneficiary’s care communicate with one another so that medical, behavioral health, and social needs are addressed in a comprehensive

manner. While States have flexibility to define health home services, they must provide six core health home services (core services) specified in the Act: comprehensive care management, care coordination, health promotion, comprehensive transitional care and followup, patient and family support, and referral to community and social support services, if relevant (the Act § 1945(h)(4)(B)). (See more detailed discussion of core services in “Missouri’s Medicaid Health Home Program” below.)

To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following: two chronic conditions, one chronic condition and risk for a second, or a serious and persistent mental health condition (the Act § 1945(h)(1)(A)). The Act directs that States specify, in relevant SPAs, the methodologies they will use to determine payment for health home services (the Act § 1945(c)(2)(A)). Beneficiaries enrolled in a health home program receive services through a network of providers, health plans, and community-based organizations.

Federal and State Requirements

Federal reimbursement is available only for allowable actual Medicaid expenditures for which there is adequate supporting documentation.¹ Requirements for Missouri’s health home program are detailed in its Medicaid State plan (including the relevant SPAs), which requires health home providers to document, in each enrolled beneficiary’s medical record or other documentation, that the beneficiary met all applicable requirements identified in the SPAs. Specifically, to enroll in a health home program, a beneficiary must meet the qualifying condition requirements of one of the two health home programs discussed below. To bill for and receive payment from the State agency for a beneficiary, a health home provider must ensure that the beneficiary: (1) meets the health home eligibility criteria, (2) has enrolled with the designated health home provider, and (3) received care management monitoring for treatment gaps or another health home service (e.g., one of the core services discussed below).

Missouri’s Medicaid Health Home Program

Missouri has operated a Medicaid health home program since calendar year (CY) 2012. Health home providers directly provide health home services to eligible and enrolled beneficiaries. The State agency is primarily responsible for monitoring and overseeing the health home program. The State agency’s monitoring activities include determining whether health home providers have documentation that enrolled beneficiaries met the eligibility requirements discussed above and that the beneficiaries received health home services as defined in the relevant SPAs.

The State agency administers two health home programs: a Primary Care Health Home (PCHH) and a Community Mental Health Center Healthcare Home (CMHC). Both programs require

¹ CMS *State Medicaid Manual* (the Manual) § 2497.1.

health home providers to furnish at least one core service (discussed below) to enrolled beneficiaries.

The State agency made payments to health home providers using a payment model that allowed those providers to bill the State agency and receive a per member-per month (PMPM) payment for providing at least one health home service to a Medicaid beneficiary for a month.²

Core Health Home Services

Health home providers must furnish at least one of the six core services per month to receive a PMPM payment (SPA MO 11-0011, SPA MO 11-0015, SPA MO 16-0002, and SPA MO 16-0007):³

- comprehensive care management, which includes assessing preliminary service needs, developing treatment plans, and monitoring individual and population health status;
- care coordination, which includes referring beneficiaries to long-term services, appointment scheduling, conducting referrals and followup monitoring, and participating in hospital discharge processes;
- health promotion, which includes providing health education specific to an individual's chronic conditions, developing self-management plans with the individual, and providing support for improving social networks;
- comprehensive transitional care from inpatient care to other settings, which includes providing care coordination services designed to streamline plans of care and reduce hospitalizations;
- patient and family support, which includes advocating for individuals and families, assisting with obtaining and adhering to medication, and identifying resources for patients; and
- referrals to community and social support services, which include providing assistance for clients to obtain and maintain eligibility for health care, disability benefits, housing, and legal services.

Primary Care Health Home Program

The PCHH program covers enrolled beneficiaries who have two or more chronic conditions or have one chronic condition and are at risk of developing another. The PCHH program defines

² Although many of the policies and guidelines the State agency uses to administer the Medicaid program, including the PMPM acronym, refer to its beneficiaries as “members,” this report uses the term “beneficiaries.”

³ These are the four relevant SPAs that address both of Missouri's health home programs. For the remainder of this report, we will refer to criteria citations that encompass all four SPAs as “health home SPAs.”

qualifying chronic conditions as asthma; mental health conditions, including anxiety and depression; substance use disorder; developmental disabilities, diabetes, heart disease, and high body mass index. At-risk conditions include tobacco use, diabetes, pediatric asthma, and obesity (SPA MO 11-0015 and SPA MO 16-0002).⁴

Community Mental Health Center Healthcare Home Program

The CMHC program covers enrolled beneficiaries who have two or more chronic conditions, one chronic condition and the risk of developing another chronic condition, or one or more serious and persistent mental health condition (SMI). An SMI is a diagnosis of schizophrenia, delusional disorder, bipolar disorder, psychotic disorder, reoccurring major depressive disorder, obsessive-compulsive disorder, post-traumatic stress disorder, or borderline personality disorder (SPA MO 11-0011 and SPA MO-16-0007).⁵

Health home providers receive one payment for PCHH beneficiaries and one payment for CMHC beneficiaries.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,339,367 PMPM payments, totaling \$97,857,731 (\$62,267,981 Federal share), that the State agency made to health home providers for services paid during CYs 2016 through 2018.^{6,7} We reviewed a stratified random sample of 150 of these payments (75 PCHH payments and 75 CMHC payments). Specifically, we reviewed the health home providers' documentation and beneficiaries' medical records, or other documentation associated with the sampled payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

⁴ These are the two SPAs that are applicable to the PCHH program. For the remainder of this report, we collectively refer to these two SPAs as "PCHH SPAs." These qualifying and at-risk conditions encompass all conditions listed in both SPAs, although some conditions were not included under the earlier SPA MO 11-0015.

⁵ These are the two SPAs that are applicable to the CMHC program. For the remainder of this report, we collectively refer to these two SPAs as "CMHC SPAs." The earlier SPA MO 11-0011 does not list specific diagnoses for SMIs.

⁶ The FMAP rates during our audit period ranged from 63.28 percent to 65.40 percent.

⁷ See Appendix C for a complete description of the payments covered by this audit.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some payments made to health home providers that did not comply with Federal and State requirements. Of the 150 PMPM payments in our stratified random sample, the State agency properly claimed reimbursement for 136 payments but improperly claimed reimbursement for the remaining 14 payments. For all 150 payments, the beneficiaries had Medicaid benefits at the time Missouri issued the PMPM payments, as required by statute. In addition, for all 150 payments, health home providers ensured that: (1) each beneficiary met the eligibility criteria for enrollment in the CMHC or PCHH program and (2) each beneficiary was enrolled as a health home member only at the billing health home provider.

The 14 improper payments primarily involved deficiencies in the documentation that providers were required to maintain. Specifically, for these 14 payments Missouri's health home providers did not always document core services, despite their monthly attestation reports that the minimal service had occurred.

The improper payments occurred because the State agency did not adequately monitor health home providers for compliance with certain Federal and State requirements. The State agency had issued policy guidance to health home providers requiring them to support the PMPM payments they received by documenting the health home services they furnished. The State agency also conducted reviews to determine whether health home providers had documentation that enrolled beneficiaries met the eligibility requirements and received health home services as defined in the relevant SPAs. However, despite the State agency's monitoring efforts, some health home providers did not always comply with Federal and State requirements.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$3,411,531 in Federal Medicaid reimbursement for payments made to health home providers.⁸

CORE HEALTH HOME SERVICES NOT DOCUMENTED BUT ALL OTHER REQUIREMENTS MET

To be eligible for a PMPM payment on behalf of an enrolled beneficiary, a health home provider must ensure that the beneficiary received the minimum service requirement of care management monitoring for treatment gaps or another core health home service as defined in the State plan. The core services are comprehensive care management, care coordination, health promotion, comprehensive transitional care and followup, patient and family support, and referral to community and social support services (the Act § 1945(h)(4)(B)).

⁸ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Providers must maintain medical records that fully disclose the extent of services provided to individuals receiving Medicaid services authorized under the State plan (the Act § 1902(a)(27)).

The State agency requires that health home providers document the core service(s) provided to each beneficiary (health home SPAs).

To be eligible for a PCHH payment on behalf of an enrolled beneficiary, the health home provider must ensure that the beneficiary was diagnosed with two chronic conditions or with one chronic condition and was at risk of developing another qualifying chronic condition (PCHH SPAs).

To be eligible for a CMHC payment on behalf of an enrolled beneficiary, the health home provider must ensure that the beneficiary was diagnosed with two chronic conditions, one chronic condition and the risk of developing another chronic condition, or one or more SMLs (CMHC SPAs).

The State agency requires health home providers to ensure that each beneficiary's enrollment with the designated health home provider (health home SPAs).

Of the 150 PMPM sampled payments, health home providers met all requirements for 136 payments. For the remaining 14 sampled payments (10 of which were CMHC payments and 4 of which were PCHH payments), the health home providers billed for health home services furnished to beneficiaries. However, the providers could not provide any documentation that the beneficiaries had received care management monitoring for treatment gaps or were furnished any core services in the months associated with those sampled payments.

INADEQUATE STATE AGENCY MONITORING

The improper payments occurred because the State agency did not adequately monitor health home providers for compliance with certain Federal and State requirements. The State agency had issued policy guidance to health home providers requiring them to support the PMPM payments they received by documenting the health home services they provided. The State agency also conducted reviews to determine whether health home providers had documentation that enrolled beneficiaries met the eligibility requirements and received health home services as defined in the relevant SPAs. However, despite the State agency's monitoring efforts, some health home providers did not always comply with Federal and State requirements to ensure that health home providers documented the services furnished to beneficiaries.

COSTS ASSOCIATED WITH PAYMENTS NOT MADE IN ACCORDANCE WITH REQUIREMENTS

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$3,411,531 in Federal Medicaid reimbursement for payments made to health home providers.

RECOMMENDATIONS

We recommend that the Missouri Department of Social Services:

- refund \$3,411,531 to the Federal Government and
- improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received PMPM payments.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency addressed our second recommendation by concurring that the health home programs should be monitored. The State agency said that it “already has a robust system in place to monitor compliance, which it is continuously improving” and described its monitoring and training activities for health home providers. The State agency said that it partners with the Missouri Primary Care Association to provide technical assistance and training. In addition, the State agency stated that it works with the Missouri Behavioral Health Council to design a comprehensive CMHC training program.

The State agency did not agree with our first recommendation and disagreed with our findings. A summary of the State agency’s comments and our responses follows.

After reviewing the State agency’s comments and the additional documentation it provided, we maintain that our findings and recommendations are valid.

The State agency’s comments appear as Appendix E. We excluded four attachments because of their volume and because they contain provider-specific information. We will forward the State agency’s comments with all of the attachments in their entirety to CMS.

THE STATE AGENCY SAID THAT THE SAMPLED PAYMENTS IN OUR FINDINGS COMPLIED WITH THE STATE PLAN AND FEDERAL DOCUMENTATION REQUIREMENTS

State Agency Comments

With respect to the 14 sampled PMPM payments in our findings, the State agency stated that it “provided OIG with, for all 14 rejected claims, data from the electronic attestation reports documenting that the provider contemporaneously attested . . . that it had delivered an eligible

health home service in the month in question for the beneficiary in question.” The State agency added that we incorrectly read State plan requirements governing documentation of care management monitoring for treatment gaps, because “when the minimum service is care management monitoring, the monthly attestation by the health home serves as adequate documentation that the monitoring service was provided.” This State plan language, according to the State agency, was discussed with and approved by CMS during the SPA process.

The State agency also referred to our draft report’s reference to section 1902(a)(27) of the Act and stated that that provision does not impose documentation requirements beyond what the State and CMS have agreed to in the State plan. In this context, the State agency cited a Department of Health and Human Services, Departmental Appeals Board (DAB) decision to explain the intent of section 1902(a)(27).⁹ The State agency said that the State and CMS “agreed that the monthly provider attestation was sufficient documentation of case management monitoring ‘to assure that payments under the plan are proper.’”

The State agency stated that even if section 1902(a)(27) of the Act requires more than the monthly attestation reports, OIG received additional documentation in the form of record extracts from providers’ health information technology (HIT) care management tools. The State agency also stated that health home providers used “multiple HIT care management tools to monitor beneficiaries for treatment gaps and identify care management needs. . . . which allow the providers to identify patients who are not meeting certain clinical outcomes or measures.” The State agency then addressed the 14 sampled payments that we describe as improperly claimed, and described—using OIG sample numbers in the cases of the 4 PCHH payments—the documentation that, according to the State agency, showed that providers had been monitoring beneficiaries’ health information.

Office of Inspector General Response

We reviewed the State plan and applicable Federal requirements as well as the additional documentation that the State agency provided with its comments on our draft report. This additional documentation included copies of email communications between the State agency and CMS. The email communications support that CMS reviewed and approved the SPA, but they do not convey CMS’s specific agreement that the monthly activity report would suffice as documentation of the minimum health home services of screening for care management needs.

As to the State agency’s assertion that section 1902(a)(27) of the Act does not impose documentation requirements beyond what the State and CMS have agreed to in the State plan, section 1902(a)(27) specifically requires documentation to fully disclose the extent of services provided. As the State agency pointed out in its cited DAB decision, the legislative history of section 1902(a)(27) indicates that its focus was assuring that the State had access to records of suppliers of Medicaid services to assure that payments under the State plan are proper.

⁹ *Utah Department of Health*, DAB No. 1307 (1992).

However, based on the records we reviewed, we were unable to verify that Missouri health home payments were proper because the documentation did not sufficiently show that case management monitoring was provided. In the absence of documentation showing the specific services rendered, the State agency cannot support its claims for Federal reimbursement.

With respect to the 14 sampled payments in question (10 CMHC payments and 4 PCHH payments), the support for the 10 CMHC payments showed that the health home providers reviewed the patients' records in their electronic health record systems. However, the documentation did not support that the services were actually provided to the patients. For example, we received documentation indicating that a health home provider "checked" all of the patients in its system. But we did not receive documentation supporting what the provider reviewed in the sampled patient's records and what conclusions the provider reached concerning the patient's care based on its review. In addition, the attestations that the provider completed do not indicate the specific health home services that the provider performed.

For the four PCHH payments that we identified as improperly claimed, we reviewed the documentation we obtained from the State agency and providers during our audit, and the additional documentation that the State agency included with its comments on our draft report, and reached the following conclusions:

- For sample number 14, the medical record indicated that there was a missed call when the health home provider attempted to contact the patient. There was no indication in the medical record that any health home service was performed.
- For sample number 35, the documentation we received said only that there was a missed call from the health home provider to the patient. We did note an office visit with the patient's primary care provider during our sampled month, but there was no support in the medical record that the health home provider assessed the patient's records, performed medication reconciliation, or conducted any other activities.
- For sample number 67, the documentation supported that the health home provider sent a letter to the patient indicating that the provider had been unable to contact the patient. There was no documentation showing that a core health home service was provided to this patient in the sampled month.
- For sample number 45, the documentation did not show what the health home provider reviewed in the patient's record and what health home service was performed. Therefore, there was no support that a core health home service was performed.

THE STATE AGENCY SAID THAT THE SAMPLED PAYMENTS CONSIDERED IN ERROR DID NOT VIOLATE STATE POLICY

State Agency Comments

The State agency agreed that under the State plan, health home services other than care management monitoring are to be documented by a health home director, nurse care manager, or both. The State agency added that it “does not have a policy that care management monitoring must be documented separate and apart from the attestation that the service was provided.” The State agency also said that noncompliance with State law or policy is not a valid basis for recommending a refund of the Federal share.

Office of Inspector General Response

Our findings and recommendations are based on Federal requirements. We referred to the State’s policy guidance merely to explain that despite the State agency’s monitoring efforts, some providers did not always comply with Federal requirements. The health home SPAs require provision of at least one of the six core services per month in order to receive a PMPM payment. As explained above, section 1902(a)(27) of the Act requires documentation to fully disclose the extent of services provided. Section 2497.1 of the CMS *State Medicaid Manual* (the Manual) further states that Federal reimbursement is available only for allowable actual expenditures with adequate supporting documentation to assure that all applicable Federal requirements have been met. The support that we obtained from the health home providers did not adequately document the services for which providers claimed payment and the State agency claimed Federal Medicaid reimbursement. A file supporting only that the health home providers looked at patient information in their electronic health record systems does not constitute adequate documentation to support that care management monitoring services were provided to the patients in our sample.

THE STATE AGENCY SAID THAT OFFICE OF INSPECTOR GENERAL HAS NOT ADEQUATELY EXPLAINED ITS BASIS FOR REJECTING THE SAMPLED PAYMENTS IN QUESTION

State Agency Comments

The State agency said that it could not “fully evaluate” our first recommendation because “the basis for each specific finding is unclear.” The State agency asked us to provide documentation showing our basis for rejecting the sampled payments in question, a citation of any legal provisions or policies that we believe were violated, and a description of any documentation that we believe was missing or deficient for the payments in question.

Office of Inspector General Response

Contrary to the State agency’s assertions, both during our audit and at the exit conference we gave State agency staff the reason for each of the 14 rejected PMPM payments in our findings.

For the 10 rejected CMHC payments, the State agency did not have documentation that allowable services were performed in the sampled months. For the State agency to have properly claimed Federal reimbursement for each of these payments, the health home providers would have to have performed an allowable health home service during the sampled month and have documented it in the patient's record. Documentation showing only that the provider reviewed patient files does not identify exactly what was reviewed or, for that matter, that the specific patient associated with the sampled payment was reviewed.

For the four rejected PCHH payments, the support provided by the health home providers and the State agency was not adequate to determine that care management monitoring for treatment gaps was performed by the health home providers. In the cases of these four PCHH payments (discussed above), there was no documentation in the records that showed what service(s) was performed. For the State agency to have properly claimed Federal reimbursement for these payments, the health home providers would have to have had documentation supporting what monitoring for treatment gaps had been performed during the month. The documentation, including the attestations, that we reviewed did not support that an allowable health home service was provided.

The health home SPAs require provision of at least one of the six core services per month in order to receive a PMPM payment. Section 1902(a)(27) of the Act states that providers must maintain medical records that fully disclose the extent of services provided to individuals receiving Medicaid services authorized under the State plan. Section 2497.1 of the Manual further states that Federal reimbursement is available only for allowable actual expenditures with adequate supporting documentation to assure that all applicable Federal requirements have been met.

The support provided by the health home providers and the State agency for the 14 PMPM payments that we identified as improperly claimed did not fully disclose the nature and extent of the services provided, and there is no record of the services that were performed. Thus, the services provided were not adequately documented and the health home payments were not allowable.

THE STATE AGENCY SAID THAT EXTRAPOLATION WAS INAPPROPRIATE IN THIS AUDIT

State Agency Comments

The State agency said that PCHH and CMHC are “two separate programs, with two distinct sets of providers serving two different populations, paid at different rates, which were established through separate [SPAs]. As a result, inferences about the PCHH program cannot be made based on the identification of errors in a sample of CMHC claims, and vice versa.” For that reason, our selection of a sample of 150 PMPM payments, with 75 samples drawn from each program, was, according to the State agency, inconsistent with our own guidance that the minimum sample size is 100 units. The State agency added that our sample size, which it described as “too small,” led to a “lack of precision” in our statistical analysis.

The State agency also stated that extrapolation was “unwarranted in light of the high rate of compliance in the PCHH program.” In addition, the State agency said that historically, we do not make a statistical projection when we find less than 6 errors in a 100-claim sample (i.e., an error rate of 6 percent). The State agency said, “Given that OIG long believed that the 6-error threshold was sound statistical practice, and its elimination of that policy was not accompanied by any reasoned explanation for the change, the 6-claim threshold should still apply.”

Office of Inspector General Response

We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria for each stratum in evaluating the sample, and used OIG, Office of Audit Services (OAS), statistical software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation (Appendices C and D). Because we stratified by health home program—with CMHC payments in Stratum 1 and PCHH payments in Stratum 2—and applied the relevant criteria for each stratum, we ensured that the results of each program were extrapolated back to that program. We therefore conformed to our own guidance and processes regarding statistical sampling, in that our sample design and sample size ensured that we made no inferences about the PCHH program based on the identification of errors in a sample of CMHC claims, and no inferences about the CMHC program based on the identification of errors in a sample of PCHH claims.

To ensure that our estimate is reasonably conservative regardless of the differences between the population and the sample, we recommend recovery at the statistical lower limit of a two-sided 90-percent confidence interval.¹⁰ Lower limits calculated in this manner are designed to be less than the actual overpayment in the sampling frame 95 percent of the time. The use of the lower limit also accounts for any imprecision resulting from the choice of sample design and sample size. See *Puerto Rico Department of Health*, DAB No. 2385, at 10 (2011); and *Oklahoma Department of Human Services*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the “benefit of any doubt” raised by use of a smaller sample size).

Regarding the State agency’s objections to our statistical sampling and extrapolation methodology, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid. See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912

¹⁰ In its comments on our draft report, the State agency asserted that the distribution of the amounts paid in the sample differed significantly from the distribution of the amounts paid in the sampling frame. We do not think such tests are appropriate given that the rejection of a sample by such a test would mean that each potential sample would no longer have a known chance of being selected. Nevertheless, even if such a test were reasonable, the State agency performed the test incorrectly because it did not account for the stratified nature of the sampling design.

F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology. See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *33-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

We maintain that our statistical approach resulted in a legally valid and reasonably conservative estimate of the unallowable health home payments for which the State agency claimed reimbursement.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 1,339,367 PMPM payments, totaling \$97,857,731 (\$62,267,981 Federal share), that the State agency made to health home providers for services paid during CYs 2016 through 2018 (Appendix C). We reviewed a stratified random sample of 150 of these payments (75 PCHH payments and 75 CMHC payments). Specifically, we reviewed the health home providers' documentation and beneficiaries' medical records, or other documentation associated with the sampled payments.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the State agency's Medicaid Management Information System (MMIS) for our audit period.¹¹ We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS to the State agency's claims for reimbursement on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medicaid Program (Form CMS-64).

We determined that the State agency's control environment, information and communication, and monitoring were significant to our audit objective. We assessed the design and implementation of the State agency's internal controls related to payments made to health home providers. We met with State agency officials to gain an understanding of the organizational structure, responsibility, and delegation of authority in the health home program. In addition, we reviewed the State agency's quality information regarding the health home programs and how that information was communicated. Finally, we met with State agency officials to gain an understanding of the procedures in place for monitoring the health home program as well as identifying and remediating deficiencies in the program.

We performed fieldwork at the State agency in Jefferson City, Missouri. We reviewed Missouri's health home providers through desk reviews.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with State agency officials to gain an understanding of the State agency's administration and monitoring of the health home program;

¹¹ The MMIS is a computerized payment and information reporting system that the State agency uses to process and pay Medicaid claims and to manage information about Medicaid beneficiaries and services.

- interviewed health home provider officials associated with the sampled payments to gain an understanding of their health home program policies and procedures, including determining beneficiary eligibility and enrollment, furnishing core services, and documenting health home services;
- requested and received, from the State agency's MMIS data files, details on all payments to health home providers for which the State agency claimed Medicaid reimbursement for health home services furnished during CYs 2016 through 2018;¹²
- reconciled the claim data in the MMIS to the State agency's claims for reimbursement on the Form CMS-64;
- removed retroactive adjustments and accounts receivable from the sampling frame (Appendix C);¹³
- created a sampling frame of 1,339,367 payments made to health home providers totaling \$97,857,731 (\$62,267,981 Federal share) (Appendix C);
- requested and received the State agency's Medicaid eligibility data file and used it in our review of the sampled payments;
- selected a stratified random sample of 150 PMPM payments and, for each payment, determined whether:
 - o the beneficiary received at least 1 of the 6 core services per month,
 - o the beneficiary, if enrolled in the PCHH program, either was diagnosed with 2 qualifying chronic conditions or was diagnosed with 1 qualifying chronic condition and was at risk of developing another qualifying chronic condition,
 - o the beneficiary, if enrolled in the CMHC program, was diagnosed with 2 or more chronic conditions, 1 chronic condition and the risk of developing another chronic condition, or 1 or more serious SMIs,
 - o the beneficiary had enrolled with the designated health home provider,

¹² The data files contained payments totaling \$97,189,323.

¹³ Retroactive adjustments as well as accounts receivables included PMPM payments for prior months or years that totaled (\$668,408). We did not include these payments within the sampling frame because we could not determine which PMPM payments in the frame had been corrected by the adjustments. Although we could not determine the adjustments for all items in the frame, we were able to make the determination for each item in the sample.

- o the health home provider reported on a monthly health home activity report that the minimal service required for a PMPM payment had occurred, and
 - o the beneficiary, according to the Medicaid eligibility data file, had Medicaid benefits at the time the PMPM payment was made;
- used the results of the sample to estimate the unallowable Federal Medicaid reimbursement to the State agency for our audit period; and
- summarized the results of our audit and discussed these results with State agency officials on December 9, 2020.

Appendix C contains our statistical sampling methodology and Appendix D contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|--|--------------------------------------|-------------|
| <i>North Carolina Received \$30 Million in Excess Federal Funds Related to Improperly Claimed Health Home Expenditures</i> | <u>A-04-18-00120</u> | 4/29/2020 |
| <i>Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement</i> | <u>A-07-18-04109</u> | 4/7/2020 |
| <i>New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements</i> | <u>A-02-17-01004</u> | 7/1/2019 |

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 1,339,367 PCHH and CMHC PMPM payments totaling \$97,857,731 (\$62,267,981 Federal share) for which the State agency claimed Federal Medicaid reimbursement for services paid during CYs 2016 through 2018.¹⁴ We requested and received, from the State agency's MMIS data files, details on all of these payments to health home providers.

SAMPLE UNIT

The sample unit was one PMPM payment made to a health home provider.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample consisting of two strata. We divided the strata based on the health home program (PCHH or CMHC) associated with each sample item, as follows:

Table 1: Sample Strata

| Stratum | Stratum Description | Number of Frame Units | Frame Dollar Value (Federal Share) | Sample Size |
|----------------|----------------------------|------------------------------|---|--------------------|
| 1 | CMHC PMPM payments | 587,111 | \$31,713,793 | 75 |
| 2 | PCHH PMPM payments | 752,256 | 30,554,188 | 75 |
| | Total | 1,339,367 | \$62,267,981 | 150 |

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, OAS, statistical software.

¹⁴ The sampling frame total dollar amount (\$97,857,731) is larger than the files provided by the State agency (\$97,189,323), because we removed the retroactive adjustments and accounts receivable from the sampling frame.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After generating 75 random numbers for Stratum 1 and 75 for Stratum 2, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of unallowable health home payments for which the State agency claimed reimbursement at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

| Stratum | Payments in Frame | Value of Frame (Federal Share) | Sample Size | Value of Sample (Federal Share) | No. of Unallowable Payments | Value of Unallowable Payments (Federal Share) |
|----------------|--------------------------|---------------------------------------|--------------------|--|------------------------------------|--|
| 1 | 587,111 | \$31,713,793 | 75 | \$4,058 | 10 | \$540 |
| 2 | 752,256 | 30,554,188 | 75 | 3,050 | 4 | 162 |
| Total | 1,339,367 | \$62,267,981 | 150 | \$7,108 | 14 | \$702 |

Table 3: Estimated Value of Unallowable Payments (Federal Share) in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

| | |
|----------------|-------------|
| Point estimate | \$5,853,268 |
| Lower limit | 3,411,531 |
| Upper limit | 8,295,006 |



MICHAEL L. PARSON, GOVERNOR • JENNIFER TIDBALL, ACTING DIRECTOR

P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING • JEFFERSON CITY, MISSOURI 64603
 WWW.DSS.MO.GOV • 800-735-2966

June 1, 2021

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

RE: Report Number: A-07-20-04117

Dear Mr. Cogley:

This letter is in response to the Office of Inspector General's ("OIG") draft report, *Missouri Claimed Federal Reimbursement for \$3.4 Million in Payments to Health Home Providers That Did Not Meet Medicaid Requirements* ("Draft Report").

The Missouri Department of Social Services ("DSS") disagrees with the Draft Report's recommendation that it return \$3,411,531 to the federal government. As explained below, the claims sampled from the Community Mental Health Center Healthcare Home ("CMHC") program and the Primary Care Health Home ("PCHH") program comply with federal requirements. In addition, the OIG's use of extrapolation in the Draft Report is inappropriate.

1. The Claims Rejected by OIG Complied with the State Plan and Federal Documentation Requirements.

Section 1945 of the Social Security Act ("SSA") provides that the health home benefit includes the following services:

- (i) comprehensive care management;
- (ii) care coordination and health promotion;
- (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- (iv) patient and family support (including authorized representatives);
- (v) referral to community and social support services, if relevant; and
- (vi) use of health information technology to link services, as feasible and appropriate.

AUXILIARY AIDS AND SERVICES ARE AVAILABLE UPON REQUEST TO INDIVIDUALS WITH DISABILITIES

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RELAY MISSOURI: 711

Missouri Department of Social Services is an Equal Opportunity Employer Program.

SSA § 1945(h)(4)(B).

Missouri has implemented two health home programs, the PCHH program and the CMHC program, both of which pay health homes on a per member per month (“PMPM”) basis. The CMS-approved Missouri state plan provides that the criteria required for a provider to receive a monthly PMPM payment are as follows:

- A. The person is identified as meeting ☐ health home eligibility criteria on the State-run patient registry;
- B. The person is enrolled as a health home member at the billing health home provider and is enrolled in only one health home at a time;
- C. The minimum health home service required to merit PMPM payment is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided that was documented; and
- D. The health home will report that the minimum service required for the PMPM payment occurred on a monthly health home attestation report.

Attachment 4.19-B, at 48-49 (CMHC Program).¹

In the Draft Report, OIG concluded that 14 health home claims – 10 from the CMHC program and 4 from the PCHH program – were unallowable because the “providers could not provide documentation that the beneficiaries had received care management monitoring for treatment gaps or were furnished any core [health home] services in the months associated with those sampled payments.” Draft Report, at 6.

This is incorrect: Consistent with the above-quoted state plan requirements, the State provided OIG with, for all 14 rejected claims, data from the electronic attestation reports documenting that the provider contemporaneously attested in CyberAccess – DSS’s electronic health record application (“EHR”) – that it had delivered an eligible health home service in the month in question for the beneficiary in question. The underlying attestations shown in the aggregate report were all completed by the providers no later than the 15th of the month

¹ The quoted language comes from the current state plan provision governing the CMHC program. There are small differences between the state plan language governing the CMHC program and the state plan language governing the PCHH program that are not material to the findings of the Draft Audit Report. For example, clause (C) in the PCHH state plan language specifies that the “another health home service” should be documented “by a health home director and/or nurse care manager.” In addition, in clause (D), the state plan language for the PCHH program provides that the health home will report the minimum service required on “a monthly health home activity report,” rather than a “monthly health home attestation report.”

following the service month (after the 15th of the month following the service month, CyberAccess precludes attestation and the attestation reports are uploaded into a master file).²

To the extent OIG takes the position that the Missouri Medicaid state plan requires documentation of care management monitoring for treatment gaps separate and apart from these attestations, that is an incorrect reading of the state plan. The plan clearly refers to the minimum health home service as “Care Management monitoring for treatment gaps” or “another health home service . . . that was documented.” Accordingly, when the minimum service is care management monitoring, the monthly attestation by the health home serves as adequate documentation that the monitoring service was provided.

This plan language was discussed with and approved by the Centers for Medicare & Medicaid Services (“CMS”) during the state plan amendment (“SPA”) review process. In 2011, when DSS was developing its first health home SPA, DSS explained to CMS that the minimum health home service required for a PMPM payment would be “screen[ing] monthly using one or more [health information technology (‘HIT’)] tools for identifying care management needs,” and DSS proposed that the state plan provide that the health home would document the provision of this electronic screening through “a monthly [health home] activity report.” See Ex. A. CMS agreed this would suffice, *id.*, and approved a SPA that required providers to document the provision of the minimum health home services with “a monthly health home activity report,” see SPA TN #MO-11-0011 (CMHC); SPA TN #MO-11-0011 (PCHH). Several years later, the CMHC state plan provision was amended to clarify that this monthly report would be a “monthly health home attestation report.” Attachment 4.19-B, at 48 (CMHC) (emphasis added).

The Draft Audit Report refers in passing to Section 1902(a)(27) of the SSA, but that provision does not impose documentation requirements beyond what Missouri and CMS have agreed to in the state plan. Section 1902(a)(27) simply requires the State to enter into provider agreements in which the provider “agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.” As the Departmental Appeals Board has explained, “[t]he legislative history of [Section] 1902(a)(27) indicates that its focus was assuring that the state had access to records of suppliers of Medicaid services to assure that payments under the plan are proper.” *Utah Dept. of Health*, DAB No. 1307, at 7 (1992). In this case, the state and CMS agreed that the monthly provider attestation was sufficient documentation of case management monitoring “to assure that payments under the plan are proper.”

But even if Section 1902(a)(27) requires more than the monthly attestation reports, OIG received additional documentation from the State and the audited health home providers

² DSS also provided OIG with a PowerPoint training presentation for health home providers, pages 6-7 of which shows a screenshot of what the providers see in CyberAccess when they are attesting to the delivery of health home services.

showing that the rejected claims reflected valid health home services (i.e., care management monitoring). Specifically, OIG received record extracts from the providers' HIT care management tools showing that the provider had reviewed the beneficiary's health information to identify treatment gaps during the month in question.

As background, CMHC and PCHH providers used multiple HIT care management tools to monitor beneficiaries for treatment gaps and identify care management needs: CMHC providers used ProAct in audit years 2016 and 2017 and CareManager in audit year 2018; PCHH providers used their own internal EHR systems, along with CyberAccess.³ These HIT care management tools combine information from a number of sources to create population and individual reports on health home quality measures, which allow the providers to identify patients who are not meeting certain clinical outcomes or measures. For those patients who are flagged as not meeting an outcome or measure, the health home provider then determines what intervention is appropriate; for the patients who are assessed and the HIT tool shows they are meeting the key outcomes and measures, the health home provider need not take any additional assessment or intervention steps that month. This use of HIT tools is a "key" part of the health home service,⁴ as the tools efficiently identify beneficiaries who are failing to receive necessary services and thus need further intervention.⁵

OIG received the applicable internal reports and record extracts from ProAct, CareManager and CyberAccess that document that the CMHC and PCHH providers actually used the HIT care management tools to identify treatment gaps for the months and beneficiaries associated with the 14 rejected claims:

- For the nine rejected CMHC claims from 2016 and 2017, OIG received the "HCH Patients Viewed in ProAct" report, which shows that the provider opened and reviewed all of its patients' health information for treatment gaps in ProAct for the month in question. The Monthly Implementation Report from the service months provides further support that the provider used HIT tools to provide care management monitoring for treatment gaps. In the service month of each of the rejected claims the health home provider checked "Yes" on the report line stating, "Please indicate whether your Healthcare Home has reviewed the care management data for enrolled members for the month of [Month] [Year]."⁶

³ CMHC providers also have access to and use CyberAccess to engage in care management monitoring.

⁴ CMS, *Health Home (Section 2703) Frequently Asked Questions*, at 8 (Dec. 2015), <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf>.

⁵ See SAMHSA-HRSA, Center for Integrated Health Solutions, *Population Management in Community Mental Health Center-Based Health Homes* (Sept. 2014).

⁶ The Monthly Implementation Report for Sample No. 8 asks the health home provider to "Please indicate whether your Healthcare Home has reviewed the Behavioral Pharmacy Management data in ProAct for enrolled members for the month of [Month] [Year]" by checking "Yes." The Behavioral Pharmacy Management data report in ProAct is one of three primary reports utilized by health home providers to monitor patients for treatment gaps. For the first few months of the audit period, it was DMH policy that health home providers focus on a specific report each month on a rotation. This policy was in place during the service month for Sample No. 8, which is why the Monthly Implementation Report language is different. DMH subsequently changed this policy and no longer

Copies of the Monthly Implementation Reports for the nine rejected CMHC claims from 2016 and 2017 are attached to this response as Exhibit B.

- For the one rejected CMHC claim from 2018 audit, OIG received the “CareManager Population Health Logins,” which show that the health home provider logged-in to CareManager multiple times during the relevant month to review patient health information to monitor for potential treatment gaps. (OIG also received the CareManager Population Quality Report for the specific patient, which shows the individualized performance data across all of the quality measures that the providers saw in CareManager for that month).
- For two of the four rejected PCHH claims, Sample Nos. 14 and 45,⁷ the State provided the “Cyber Touches Agency Summary” report, which show that members of the health home team accessed the specific patient’s records in CyberAccess. Each of these reports also identifies the features of CyberAccess that were used in the month of the rejected claim. (OIG also received documentation from the health home providers’ own EHR systems, which shows that the patient’s health information was being monitored for treatment gaps during the service month).
- For one rejected PCHH claim, Sample No. 35, OIG received documentation from the provider’s own EHR application, which shows that the health home care manager assessed the specific patient’s records in the provider’s internal EHR system, supporting that the health home provided comprehensive care management services. (For the sample month, OIG also received extensive documentation of an office visit where health team members performed medication reconciliation, a complete physical exam with a detailed treatment plan, and obtained vitals with Body Mass Index, blood pressure and pulse oximetry readings. These records further support that comprehensive care management was provided in the service month and documented in the patient’s record).
- For one rejected PCHH claims, Sample No. 67, OIG received documentation from the specific patient’s EHR, which support that the health home provided comprehensive care management services. A progress note from the nurse care manager in the specific patient’s EHR provides further support that a health home service was provided in the service month and documented in the patient’s record. A copy of the progress note for Sample No. 67 is attached to this response as Exhibit D. (For the sample month, OIG also received extensive documentation of an office visit where the behavioral health consultant

dictated the specific population health report the health home provider was required to focus on for a specific month.

⁷ OIG received this documentation for Sample No. 45 on January 8, 2021. A copy of the Cyber Touch Report for Sample No. 14 is attached to this response as Exhibit C.

performed medication reconciliation, evaluated the patient's mental and behavioral health needs, and provided a specific action plan for the patient's ongoing plan of care. These records also support that comprehensive care management was provided in the service month and documented in the patient's record).

2. The Claims Did Not Violate State Policy.

The Draft Report refers generally to "policy guidance" issued by DSS "to health home providers requiring them to support the PMPM payments they received by documenting the health home services they furnished." Draft Report, at 5. DSS agrees that, under the Medicaid state plan, health home services other than care management monitoring are to be "documented by a health home director and/or nurse care manager." As discussed above, however, DSS does not have a policy that care management monitoring must be documented separate and apart from the attestation that the service was provided.

In any event, noncompliance with state law or policy is not a valid basis for recommending a refund of the federal share: state policies do not govern when federal financial participation is available from the federal government, *see* 42 C.F.R. § 430.10 (the state plan, not state regulations or guidance, "serves as a basis for Federal financial participation [] in the State program"), and the federal government lacks the authority or interest in enforcing compliance with state law through a federal disallowance, *see Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 105-06 (1984) (explaining that the federal government lacks a general power or any interest in enforcing state government compliance with state law).

3. OIG has Not Adequately Explained Its Basis for Rejecting the Fourteen Claims.

DSS is unable to fully evaluate OIG's disallowance recommendation because the basis for each specific finding is unclear from either the Draft Report or the other information provided by OIG. Accordingly, if OIG insists on moving forward with a disallowance recommendation, DSS requests that OIG provide the State with documentation showing the following for each of the 14 rejected claims:

- OIG's basis for rejecting the claim;
- a citation to any legal provision(s) or policy that OIG believes was violated; and
- a description of any documentation that OIG believes was missing or deficient for that claim.

OIG has provided DSS with a spreadsheet listing some information that allows the State to identify the rejected claims, but this information does not include a findings explanation for each claim or identify the legal provisions or policies that OIG believes were not followed for each claim.

4. Extrapolation is Inappropriate in this Audit.

OIG's Office of Audit Services' Audit Policies and Procedures Manual ("Audit Manual") states that, "for simple random sampling, the minimum sample size is 100 sample units," and "for stratified random sampling, the minimum sample size is 100 randomly selected sample units with a minimum of 30 sample units per random stratum." Audit Manual § 20-02-50-05.

In this audit, OIG treated PCHH and CMHC as parts of a single program, pulling a 150-claim sample from the over 1.3 million claims in both programs paid during calendar years 2016 through 2018. OIG broke down this 150-claim sample into two, 75-claim strata, one for the PCHH program and one for the CMHC program.

OIG should not have treated PCHH and CMHC as a single program for sampling and extrapolation purposes, but should have conducted two separate simple random samples of at least 100 sample units for each program. PCHH and CMHC are two separate programs, with two distinct sets of providers serving two different populations, paid at different rates, which were established through separate Medicaid state plan amendments. As a result, inferences about the PCHH program cannot be made based on the identification of errors in a sample of CMHC claims, and vice versa. OIG pulling a single sample from both programs, as if they were a single program, and pulling less than 100 sample claims from each program, is inconsistent with its own guidance that "the minimum sample size is 100 sample units."

The lack of precision in OIG's statistical analysis confirms that the sample size used in the Draft Report was too small. In *Central Louisiana Home Health Care, LLC v. Price*, a district court explained that the margin of error "is the most important factor for determining sample size," and found that a Medicare audit was statistically invalid because there was a 32.4 percent margin of error. 2018 WL 7888523, *19-20 (W.D. La. Dec. 18, 2018). In the Draft Report, the margin of error in the OIG's statistical analysis (41.7 percent) is even higher, indicating that the sample size was simply too small for the purpose of extrapolation.

Finally, regardless of OIG's methodology, extrapolation is unwarranted in light of the high rate of compliance in the PCHH program. Historically, OIG declined "to make a statistical projection based on [OIG's] statistical sampling policies and procedures" when it found less than 6 errors in a 100-claim sample (*i.e.*, an error rate below 6 percent).⁸ While OIG eliminated this minimum error threshold policy in March 2015, Audit Manual Transmittal No. 2015.03 (Mar. 16, 2015), it provided no rationale or justification for doing so. Given that OIG long believed that the 6-error threshold was sound statistical practice, and its elimination of that policy was not accompanied by any reasoned explanation for the change, the 6-claim threshold

⁸ *Puerto Rico Dept. of Health*, DAB No. 2385, at 12-13 (2011) (quoting Audit of Payments for Medicaid Services to Deceased Beneficiaries, A-05-03-00099 at App. A (2004)); *see also*, *Review of Personal Care Services Claimed under Maryland's Medicaid State Plan*, A-03-11-00200 at 3 (2011) ("Based on our review of 100 claims, 3 claims were unallowable because the services were unsupported by case records or insufficiently documented. Since this is below our threshold of six errors needed for a statistical projection, we have no findings nor do we offer any recommendations."); *Review of Controls at SilverScript Insurance Company to Ensure Adherence to Formularies*, A-07-11-06029 at 3 (2012) (same).

should still apply, as it has for decades. And the number of errors and the error rate in the PCHH program was *lower* than the 6-error threshold: out of 75 PCHH claims sampled, OIG rejected only four, meaning the Draft Report found an error rate of only 5.3 percent in the PCHH program.

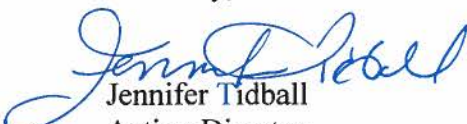
5. The State Will Continue to Monitor Its Health Home Programs.

In addition to the disallowance, OIG recommended that the State “[i]mprove its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received PMPM payments.”

DSS concurs that the programs should be monitored to ensure that service providers comply with requirements in the state plan, and with federal and state law and policy. The State already has a robust system in place to monitor compliance, which it is continuously improving. For example, DSS requires that health home providers agree to program requirements by signing a Conditions of Participation document, which includes detailed instructions for completing the documentation required to receive payment. DSS conducts training for all new health home providers through a series of webinars, one of which is devoted to complying with documentation requirements. DSS also partners with the Missouri Primary Care Association to provide Practice Transformation Coaching and Monthly Quality Coaching Outreach to PCHH providers, through which providers receive technical assistance and training. And the Department of Mental Health has worked with the Missouri Behavioral Health Council to design a comprehensive CMHC training program and a website for CMHC providers to access resources and ongoing training and technical assistance.

Please feel free to contact Alicia Kolb, Compliance Services Director, at (573) 751-2432 or at Alicia.M.Kolb@dss.mo.gov if you have any questions.

Sincerely,



Jennifer Tidball
Acting Director

JT:bb

cc: Patrick Luebbering
Donna Siebeneck