May 31, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Personal Care Services Claimed by Washington State (A-09-09-00030)

Attached, for your information, is an advance copy of our final report on Medicaid personal care services claimed by Washington State. We will issue this report to the Washington State Department of Social and Health Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-09-00030.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

June 3, 2011

Report Number: A-09-09-00030

Ms. MaryAnne Lindeblad
Assistant Secretary
Aging and Disability Services Administration
Department of Social and Health Services
P.O. Box 45050
Olympia, WA 98504

Dear Ms. Lindeblad:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Personal Care Services Claimed by Washington State.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Janet Tursich, Audit Manager, at (206) 615-2063 or through email at Janet.Tursich@oig.hhs.gov. Please refer to report number A-09-09-00030 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PERSONAL CARE SERVICES CLAIMED BY WASHINGTON STATE

Daniel R. Levinson
Inspector General

June 2011
A-09-09-00030

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. Within the State agency, the Aging and Disability Services Administration (the Administration) operates the personal care services program. The Administration provides personal care services to beneficiaries throughout Washington State using a network of State-run regional and local offices, contractors, individual providers, and home-care agencies.

Pursuant to 42 CFR § 440.167, personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases. The services must be authorized by a physician pursuant to a plan of treatment or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State agency. Examples of personal care services include, but are not limited to, cleaning, shopping, grooming, and bathing.

Section 1902(a)(27)(A) of the Act requires providers to keep records that fully disclose the extent of the services provided to Medicaid beneficiaries receiving assistance under the State plan. Pursuant to 42 CFR § 433.32(b), a State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will retain records for 3 years from the date of submission of a final expenditure report. Pursuant to Washington State's regulations, providers of personal care services must keep complete and accurate timesheets that are accessible to the case manager and successfully complete certain training requirements within specified time limits. State agency guidance requires individual providers to keep timesheets for 2 years from the month in which personal care services were provided.

For our audit, we reviewed a random sample of 100 beneficiary-months. A beneficiary-month represented the Medicaid costs for personal care services delivered by one provider to one beneficiary during the month.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for personal care services in compliance with Federal and State requirements.

SUMMARY OF FINDINGS

During the 2-year period October 1, 2006, through September 30, 2008, the State agency did not always claim Federal Medicaid reimbursement for personal care services in compliance with Federal and State requirements. Of the 100 sampled beneficiary-months, the State agency complied with requirements for 50 beneficiary-months. The State agency did not comply with Federal requirements for the 50 remaining beneficiary-months. For 26 beneficiary-months, totaling $10,525, providers did not comply or only partially complied with Federal and State timesheet or training requirements. For these beneficiary-months, providers:

- did not have timesheets supporting daily hours of service provided to the beneficiaries (12 beneficiary-months),

- claimed more hours than were recorded on the timesheets (5 beneficiary-months), and

- had not completed required training within the specified timeframes or before services were provided to the beneficiaries in our sample (9 beneficiary-months).

These deficiencies occurred because the State agency did not adequately monitor providers for compliance with certain Federal and State requirements. Based on our sample results, we estimated that the State agency claimed $19,438,693 in Federal Medicaid reimbursement for unallowable costs.

For the 24 remaining beneficiary-months, totaling $9,712, individual providers did not have timesheets supporting daily hours of service provided to the beneficiaries. At the time of our review, more than 2 years had passed since the months of service. Because Federal regulations require that records be retained for 3 years after the submission of a final expenditure report, the State agency was not in compliance with Federal regulations. We have set aside these services for resolution by CMS and the State agency because the providers may have followed State agency guidance and disposed of the timesheets after 2 years. We estimated that the State agency may have improperly claimed $30,323,597 in Federal Medicaid reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund $19,438,693 to the Federal Government,

- work with CMS to resolve the $30,323,597 that we set aside,

- improve its monitoring of providers to ensure compliance with Federal and State requirements, and

- revise its guidance to require providers to retain timesheets for 3 years.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency did not concur with our first recommendation. The State agency said that personal care services were provided despite documentation discrepancies and that it has other mechanisms besides timesheets to monitor whether services were provided. The State agency did not explicitly address providers' compliance with training requirements. The State agency listed numerous corrective actions that it had taken or planned to take to enhance the timekeeping process and the training provision and tracking system.

The State agency concurred with part of our second recommendation (to work with CMS) but did not concur with the set-aside or its amount, referring to its comments on the first recommendation. The State agency concurred with our third and fourth recommendations and provided information on corrective actions that it planned to take. The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding our first recommendation, the Act requires providers to keep records that fully disclose the extent of the services provided to Medicaid beneficiaries, and Washington State regulations require that providers keep current and accurate timesheets. Therefore, we continue to recommend that the State agency refund $19,438,693. Regarding our second recommendation, we maintain that the set-aside amount is valid.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Washington State's Medicaid Program

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. The State agency uses the Medicaid Management Information System, a computerized payment and information system, to process and pay Medicaid claims. The State agency uses a second system, the Social Services Payment System, to process and pay Medicaid social service claims, such as those for personal care services.

The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From October 1, 2006, through September 30, 2007, the FMAP in Washington State was 50.12 percent, and from October 1, 2007, through September 30, 2008, the FMAP was 51.52 percent.

The State agency submits a quarterly expenditure report to CMS, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). Form CMS-64 details all expenditures for the quarter, adjustments, and FMAP allocations. The expenditures claimed on Form CMS-64 must comply with the State plan and Federal requirements.

Washington State's Personal Care Services Program

Within the State agency, the Aging and Disability Services Administration (the Administration) operates the personal care services program. The Administration is composed of four service groups: (1) home and community, (2) developmental disability, (3) residential care, and (4) management. One way that the Administration assists adults with disabling conditions due to aging, disease, or accident and children and adults with developmental disabilities is through personal care services. The Administration provides personal care services to beneficiaries throughout Washington State using a network of State-run regional and local offices, contractors, individual providers, and home-care agencies (agency providers).

The Washington Administrative Code (WAC), § 388-106-0010, defines personal care services as "physical or verbal assistance with activities of daily living and instrumental activities of daily living due to … functional limitations." The activities of daily living include eating, toilet use,

medication management, bathing, dressing, and locomotion. The instrumental activities of daily living include meal preparation, housework, essential shopping, and travel to medical services.

To determine whether a beneficiary qualifies for personal care services, the State agency conducts an initial needs assessment. A State case manager performs the initial assessment in the beneficiary's home or another setting by asking questions and observing the beneficiary.

An individual or agency provider may deliver personal care services in the beneficiary's home. Pursuant to State regulations, an individual provider must be at least 18 years of age, pass a criminal background check, sign a provider contract/agreement with the State agency, and fulfill certain training requirements. An agency provider must have a current Washington State business license; sign an agreement with Washington State; and hire, train, and supervise its personal care services caregivers.

Individual and agency providers must complete monthly timesheets that show the number of hours of personal care services provided per day to each beneficiary and the various tasks performed during the month. Providers and beneficiaries are required to sign and retain copies of timesheets. Individual providers must keep timesheets that are accessible to the case manager for 2 years from the month in which services were provided.

The State agency pays individual and agency providers an hourly rate that is updated annually. Providers notify the State agency of the hours worked during the month by mailing invoices to the State agency or by calling an automated answering system. Providers and beneficiaries are not required to submit timesheets to the State agency.

Federal Requirements Related to Personal Care Services

The State agency must comply with certain Federal requirements in determining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases. The services must be (1) authorized by a physician pursuant to a plan of treatment or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State agency; (2) provided by an attendant who is qualified to provide such services and who is not the recipient's legally responsible relative; and (3) furnished in a home or, at the State agency's option, at another location.[1]

Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Specifically, section C.1.c of Attachment A states that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

[1] Washington State beneficiaries may also receive personal care services in a residential setting, such as an adult family home or a boarding home.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for personal care services in compliance with Federal and State requirements.

Scope

For the 2-year period October 1, 2006, through September 30, 2008, we limited our audit to certain Medicaid costs claimed for personal care services delivered by certain providers to long-term-care beneficiaries as authorized under the State plan. We excluded:

- providers serving beneficiaries receiving personal care services under various waiver programs;[2]
- residential providers;[3]
- expenditures claimed for activities such as orientation, training, and transportation; and
- beneficiary-months in which the claimed amount was less than $100.[4]

After taking into account the exclusions above, we determined that the State processed and claimed 312,232 beneficiary-months totaling $320,195,716 ($162,946,965 Federal share) for personal care services during the audit period. We reviewed a random sample of 100 beneficiary-months.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork at the State agency's offices in Lacey, Washington, and at 12 Area Agencies on Aging, 3 State agency regional offices, and 14 agency providers throughout Washington State. We visited no individual providers.

[2] Under various waivers authorized under section 1915(c) of the Act, States may receive approval from CMS to fund Medicaid home and community-based services without meeting State plan requirements. These waivers allow States to limit the availability of services geographically, target specific populations or conditions, control the number of individuals served, and cap overall expenditures.

[3] A residential provider is a facility that is licensed as an adult family or boarding home under contract with the State agency.

[4] A beneficiary-month represented the Medicaid costs for personal care services delivered by one provider to one beneficiary during the month.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency and CMS officials to gain an understanding of the personal care services program;
- interviewed State agency, Area Agencies on Aging, and agency provider officials to identify policies and procedures related to the personal care services program;
- obtained from the State agency's Social Services Payment System a data file of claim lines for personal care services for long-term-care beneficiaries under the State plan;
- created a sampling frame that contained 312,232 beneficiary-months, totaling $320,195,716 ($162,946,965 Federal share);
- reconciled the $320,195,716 claimed for personal care services to the amount reported on Form CMS-64;
- selected from the sampling frame a simple random sample of 100 beneficiary-months for which we:
    - reviewed the provider's documentation (e.g., valid contracts/agreements with the State agency, background checks, and training certificates) to determine whether the provider was qualified,
    - reviewed the timesheet(s) supporting the beneficiary-month,[5]
    - reviewed the provider's corresponding beneficiary file for the beneficiary-month, and
    - reviewed the State agency's electronic Comprehensive Assessment Reporting Evaluation file for the beneficiary; and
- estimated the unallowable and potentially unallowable Federal Medicaid reimbursement.

Appendix A contains the details of our sample design and methodology, and Appendix B 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 objective.

[5] Area Agencies on Aging staff obtained individual provider timesheets for us.

FINDINGS AND RECOMMENDATIONS

During the 2-year period October 1, 2006, through September 30, 2008, the State agency did not always claim Federal Medicaid reimbursement for personal care services in compliance with Federal and State requirements. Of the 100 sampled beneficiary-months, the State agency complied with requirements for 50 beneficiary-months. The State agency did not comply with Federal requirements for the 50 remaining beneficiary-months. For 26 beneficiary-months, totaling $10,525, providers did not comply or only partially complied with Federal and State timesheet or training requirements. For these beneficiary-months, providers:

- did not have timesheets supporting daily hours of service provided to the beneficiaries (12 beneficiary-months),

- claimed more hours than were recorded on the timesheets (5 beneficiary-months), and

- had not completed required training within the specified timeframes or before services were provided to the beneficiaries in our sample (9 beneficiary-months).

These deficiencies occurred because the State agency did not adequately monitor providers for compliance with certain Federal and State requirements. Based on our sample results, we estimated that the State agency claimed $19,438,693 in Federal Medicaid reimbursement for unallowable costs.

For the 24 remaining beneficiary-months, totaling $9,712, individual providers did not have timesheets supporting daily hours of service provided to the beneficiaries. At the time of our review, more than 2 years had passed since the months of service. Because Federal regulations require that records be retained for 3 years after the submission of a final expenditure report, the State agency was not in compliance with Federal regulations. We have set aside these services for resolution by CMS and the State agency because the providers may have followed State agency guidance and disposed of the timesheets after 2 years. We estimated that the State agency may have improperly claimed $30,323,597 in Federal Medicaid reimbursement.

NONCOMPLIANT AND PARTIALLY NONCOMPLIANT SERVICES

Timesheets Not Retained and Hours Claimed Not Supported

Pursuant to section 1902(a)(27) of the Act, a State plan for medical assistance must:

> … provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees 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 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.

Federal regulations (42 CFR § 433.32(b)) require a State plan to provide that the Medicaid agency and, where applicable, local agencies administering the plan will retain records for 3 years from the date of submission of a final expenditure report.[6]

Pursuant to WAC § 388-71-0515(10), personal care services providers must complete and keep accurate timesheets that are accessible to the social worker/case manager. Further, the State agency's *Employment Reference Guide for Individual Providers* requires individual providers to keep timesheets for 2 years from the month in which personal care services were provided.

For 17 sampled beneficiary-months totaling $4,800, providers did not comply or only partially complied with Federal and State requirements:

- For 12 beneficiary-months totaling $4,738 (all unallowable), individual providers did not have timesheets supporting daily hours of service provided to the beneficiaries. State agency guidance required providers to retain timesheets for at least 2 years following the month of service. At the time of our review, less than 2 years had passed since the months of service.

- For five beneficiary-months totaling $2,966 (of which $62 was unallowable), providers claimed more hours than were recorded on the timesheets. We questioned only the hours not supported by the timesheets.

Training Requirements Not Met

Pursuant to WAC § 388-71-0540(7), the State agency, Area Agencies on Aging, or a managed care entity will deny payment for the services of an individual or agency provider that does not successfully complete training requirements within the time limits specified in WAC §§ 388-71-05665 through 388-71-05865:

- WAC § 388-71-05730 requires individual and agency providers to complete a basic training course within 120 days after being authorized to provide personal care services for a beneficiary.

- WAC § 388-71-05780 requires individual and agency providers to complete at least 10 hours of continuing education each calendar year after the year in which they successfully complete basic training. Pursuant to WAC § 388-71-05775, continuing education is additional caregiving-related training designed to increase and keep current a person's knowledge and skills.

In addition, WAC § 257-05-160 requires individual providers to complete a safety training course no later than 120 days after beginning work with their first beneficiary.

[6] The Washington State plan, section 6.1, "Fiscal Policies and Accountability," states that the Medicaid agency administering the plan maintains an accounting system and supporting fiscal records adequate to ensure that claims for Federal funds are in accordance with 42 CFR § 433.32.

For nine sampled beneficiary-months totaling $5,725 (all unallowable), providers had not completed required training within the specified timeframes or before services were provided to the beneficiaries in our sample:

- For five beneficiary-months, individual and agency providers had not completed at least 10 hours of continuing education each calendar year after the year in which they successfully completed basic training.

- For three beneficiary-months, individual providers had not completed a safety training course within 120 days after beginning to work with their first beneficiary or before services were provided to the beneficiaries in our sample.

- For one beneficiary-month, the agency provider had not completed a basic training course within 120 days after beginning to work with its first beneficiary or before services were provided to the beneficiary in our sample.

POTENTIALLY NONCOMPLIANT SERVICES

Pursuant to section 1902(a)(27) of the Act, a State plan for medical assistance must:

> … provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees 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 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.

Pursuant to 42 CFR § 433.32(b), a State plan must provide that the Medicaid agency and, where applicable, local agencies administering the State plan will retain records for 3 years from the date of submission of a final expenditure report. However, the State agency's *Employment Reference Guide for Individual Providers* states that individual providers are required to keep timesheets for 2 years.

For 24 sampled beneficiary-months totaling $9,712, individual providers did not have timesheets supporting daily hours of service provided to the beneficiaries. Timesheets were the only documentation that supported the type and extent of services. At the time of our review, more than 2 years had passed since the months of service. Because these months of service were still within the 3-year retention period, the State agency was not in compliance with Federal regulations. The providers did not retain timesheets beyond the 2-year State agency requirement. For the sampled beneficiary-months, we did not question the costs because the providers may have followed State agency guidance and disposed of the timesheets after 2 years. We have set aside these services for resolution by CMS and the State agency.

ESTIMATES OF UNALLOWABLE AND POTENTIALLY UNALLOWABLE AMOUNTS

Of the 100 sampled beneficiary-months, 26 beneficiary-months did not comply or only partially complied with Federal and State requirements. Based on our sample results, we estimated that the State agency claimed $19,438,693 in unallowable Federal Medicaid reimbursement.

In addition, for 24 sampled beneficiary-months, we could not determine whether the services complied with Federal requirements. Based on our sample results, we estimated that the State agency potentially claimed $30,323,597 in unallowable Federal Medicaid reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund $19,438,693 to the Federal Government,
- work with CMS to resolve the $30,323,597 that we set aside,
- improve its monitoring of providers to ensure compliance with Federal and State requirements, and
- revise its guidance to require providers to retain timesheets for 3 years.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency did not concur with our first recommendation. The State agency said that personal care services were provided despite documentation discrepancies and that it has other mechanisms besides timesheets to monitor whether services were provided. The State agency did not explicitly address providers' compliance with training requirements. The State agency listed numerous corrective actions that it had taken or planned to take to enhance the timekeeping process and the training provision and tracking system.

The State agency concurred with part of our second recommendation (to work with CMS) but did not concur with the set-aside or its amount, referring to its comments on the first recommendation. The State agency concurred with our third and fourth recommendations and provided information on corrective actions that it planned to take. The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding our first recommendation, the Act requires providers to keep records that fully disclose the extent of the services provided to Medicaid beneficiaries, and Washington State regulations require that providers keep current and accurate timesheets. Therefore, we continue

to recommend that the State agency refund $19,438,693. Regarding our second recommendation, we maintain that the set-aside amount is valid.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of claim lines for personal care services submitted by providers for which the Washington Department of Social and Health Services (the State agency) claimed Federal Medicaid reimbursement during the period October 1, 2006, through September 30, 2008. We limited the population to personal care services provided to long-term-care beneficiaries as authorized under the State plan.

SAMPLING FRAME

The State agency provided us with a data file of claim lines for personal care services. This file excluded the services from various waiver programs authorized under section 1915(c) of the Social Security Act. The data extract totaled $365,980,414 and consisted of 417,492 claim lines for personal care services submitted by providers for beneficiaries in Washington State and claimed by the State agency for Federal Medicaid reimbursement during our audit period.

From the data file, we excluded claim lines for residential providers (37,855 claim lines totaling $42,967,951) and excluded claim lines related to activities such as orientation, training, and transportation (58,311 claim lines totaling $2,604,608).

The remaining 321,326 claim lines are detailed as follows:

Detail of Claim Lines

Service Code/Provider Type	No. of Claim Lines for Individual Providers	No. of Claim Lines for Home-Care Agencies
4501	188,866	
4559	10,460	
4582		48
4583		121,952

The 321,326 claim lines included multiple lines per beneficiary, provider, and service month. We combined those lines and identified 315,476 unique beneficiary-provider-service months (beneficiary-month). A beneficiary-month represented the Medicaid costs for personal care services delivered by one provider to one beneficiary during the month. From the 315,476 beneficiary-months, we excluded 3,244 beneficiary-months in which the claimed amount was less than $100. Therefore, the sampling frame consisted of 312,232 beneficiary-months for which the State agency claimed a total of $320,195,716 for personal care services during our audit period.

SAMPLE UNIT

The sample unit was a beneficiary-month with a claimed amount of $100 or more.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 beneficiary-months.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 312,232. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable and potentially unallowable amounts. Because the State agency had different Federal medical assistance percentages (FMAP) for the 2 years in our audit period, we calculated the Federal reimbursement amount for each sample beneficiary-month by applying the applicable FMAP to the total amount determined to be unallowable for the sample beneficiary-month. We used the lower limit of the 90-percent confidence interval to determine the unallowable Federal Medicaid reimbursement. We used the point estimate to determine the potentially unallowable Federal Medicaid reimbursement for the services that we set aside.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

NONCOMPLIANT AND PARTIALLY NONCOMPLIANT SERVICES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Noncompliant Beneficiary-Months[1]	Value of Noncompliant Beneficiary-Months (Federal Share)
312,232	$162,946,965	100	$50,030	26	$10,525

Estimates of Noncompliant and Partially Noncompliant Services (Federal Shares)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$32,861,700
Lower limit	19,438,693
Upper limit	46,284,707

POTENTIALLY NONCOMPLIANT SERVICES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Potentially Noncompliant Beneficiary-Months	Value of Potentially Noncompliant Beneficiary-Months (Federal Share)
312,232	$162,946,965	100	$50,030	24	$9,712

Estimates of Potentially Noncompliant Services (Federal Shares)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$30,323,597
Lower limit	19,844,864
Upper limit	40,802,330

[1] For five sample beneficiary-months, we computed a partially unallowable amount by determining the difference between the claimed hours during the month and the hours recorded on the timesheet. We multiplied the difference by the provider's applicable hourly rate of pay.

APPENDIX C: STATE AGENCY COMMENTS

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
*PO Box 45600 * Olympia, WA 98504-5600*

February 3, 2011

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 - 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-09-00030

Dear Ms. Ahlstrand:

Enclosed are Washington State's comments on the U.S. Department of Health & Human Services, Office of Inspector General *(OIG)* draft report entitled *Review of Medicaid Personal Care Services Claimed by Providers in Washington State*. An electronic copy of the State's comments has also been sent to Janet Tursich at Janet.Tursich@oig.hhs.gov and Stacy Jensen at Stacy.Jensen@oig.hhs.gov.

Please contact Marilee Fosbre at (360) 725-2536 or Marilee.Fosbre@dshs.wa.gov with any questions or additional requests.

Sincerely,

MaryAnne Lindeblad, Assistant Secretary
Aging and Disability Services Administration

Enclosure

cc: Bill Moss
Chris Imhoff
Marilee Fosbre

Washington State Medicaid Personal Care Services
OIG Report Number: A-09-09-00030
State Comments

1.) Finding:
For 26 beneficiary-months, totaling $10,525, providers did not comply or only partially complied with Federal and State timesheet or training requirements.

Recommendation:
The State agency refund $19,438,693 to the Federal Government.

State Response:
The Department does not concur with the recommendation to refund $19,438,693 to the Federal Government.

Reasons for Non-Concurrence:

- Personal care services were provided to recipients despite documentation discrepancies cited in the audit. Personal care services by definition provide assistance with very basic needs such as eating, bathing, transferring, turning and ambulation. Recipients depend on this service for daily tasks that are instrumental in maintaining their health and safety. The very nature of personal care makes it evident when it is not provided.

- The Department has other mechanisms besides a record of time sheets to monitor whether services occurred.
    - Consistent with statute, the recipient supervises their care provider and is given information on how to contact their case manager if there are concerns about service delivery. Recipients or their representatives report to case managers when services are not received.

    - In addition to self reports, case managers follow a contact schedule that includes a review of services and whether they are meeting the client's assessed needs.

    - Washington state law requires mandatory reporting of suspected abuse, neglect or exploitation of a vulnerable adult which offers additional protection to recipients who may not be receiving needed services.

    - Recipients are expected to keep copies of timesheets for their individual providers. Case managers are instructed to periodically review a sample of clients' time sheets and verify with sampled clients that authorized services have been provided and to then document the review of time sheets and the discussion of service verification in a Service Episode Record.

    - The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager. By submitting an invoice, providers attest to the accuracy of their claim. This provider attestation is no different than other types of Medicaid claims such as physician or durable medical equipment billing.

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- The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.

Corrective actions taken or planned:

a) The Department revised its form called "Acknowledgement of My Responsibilities as the Employer of My Individual Providers" to better emphasize client responsibilities as the employer of record. In the 12 month period ending October 2010, staff reviewed the revised form with all clients with all clients who employed an individual provider and will continue to do so with new clients who select an Individual Provider and with current clients who switch to an IP from a homecare agency or residential setting.

b) In April 2010, all Individual Providers delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and to complete and retain copies of their timesheets.

c) As a result of the Department's actions, the fiscal year 2010 Medicaid audit noted a significant improvement in both response to the auditors request for time sheets and in completed time sheets.

d) In 2011, Individual Providers delivering personal care services will again receive a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and complete and retain copies of their timesheets.

e) The Department is procuring a provider compensation system that will have the capacity to inform clients of provider payments. This will assist in fraud detection and prevention efforts.

f) The Department has a robust internal auditing system as part of its continuous quality improvement program. During each auditing cycle a random statistically valid sample of client files are reviewed. This review specifically includes an examination of whether provider training requirements were met. Any deficiencies noted are remediated on the individual level within 45 days of the finding.

g) Since the time the audit was completed the Department has implemented a new training provision and tracking system through the Training Partnership, a collaborative effort between the Department and the Service Employees International Union (SEIU). The Training Partnership provides all required training and tracks that all training requirements are met for all Individual Providers and those home care workers who are unionized through SEIU. Care providers receive regular written and telephonic notification of training deadlines for basic training and continuing education.

h) The Training Partnership also provides reports, updated daily, to case management staff containing information on providers' training status. This report enables staff to send notices to the provider and the client that payment will not be made to the provider if this training is not completed by the required deadline.

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2.) Finding:
Because Federal regulations require that records be retained for three years after the submission of a final expenditure report, the State agency was not in compliance with Federal regulations. We have set aside these services for resolution by CMS and the State agency because the providers may have followed State agency guidance and disposed of the timesheets after two years.

Recommendation:
The State agency work with CMS to resolve the $30,323,597 that we set aside.

State response:
The Department concurs with the recommendation to work with CMS to resolve the amount set aside. For reasons outlined in recommendation #1, the Department does not concur with this set aside or its amount.

Corrective actions taken or planned:
a) The Department will work with CMS to resolve the $30,323,597 set aside in this audit.

3.) Finding:
These deficiencies occurred because the State agency did not adequately monitor providers for compliance with certain Federal and State requirements.

Recommendation:
The State agency improves its monitoring of providers to ensure compliance with Federal and State requirements.

State Response:
The Department concurs with the recommendation to enhance monitoring of providers to ensure compliance with Federal and State requirements.

Corrective actions taken or planned:

a) The Department will implement a new Provider Compensation System (PCS) as a subsystem of Provider One, the new Medicaid Management Information System. The PCS will have the capacity to generate intermittent, random notices to a sample of clients informing them how many hours were paid to the provider on their behalf during the previous month. The clients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours paid. The PCS system is expected to be implemented by the end of 2012 and will assist the Department in fraud prevention and detection efforts.

b) A recent internal audit conducted by the Department indicated the complexity of the timesheets used by personal care providers as a possible reason for inaccuracy. The timesheet form will be reviewed for ease of use.

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c) Individual Providers delivering personal care services will again receive a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and complete and retain copies of their timesheets.

d) Until the PCS system is operational, a randomly selected sample of Individual Provider timesheets will be audited to ensure that services billed for are consistent with timesheet documentation submitted.

e) Continue to work with the Training Partnership to implement system improvements for better statewide tracking of Individual Provider training.

4.) Finding:
Pursuant to 42 CFR § 433.32(b), a State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will retain records for three years from the date of submission of a final expenditure report. However, the State agency's *Employment Reference Guide for Individual Providers* states that individual providers are required to keep timesheets for two years.

Recommendation:
The State agency revises its guidance to require providers to retain timesheets for three years.

State Response:
The Department concurs with the recommendation to change the retention requirements for provider timesheets to three years. However, the State's record for purposes of 42 CFR § 433.32(b) is the provider invoice which is submitted either through the Interactive Voice Recognition (IVR) system or on paper through the mail.

Corrective actions taken or planned:
a.) The retention requirement will be changed to a minimum of three years.