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

October 12, 2007

Report Number: A-01-06-00011

Mr. Terry Briggs
President
Center for Living and Working, Inc.
484 Main Street, Suite 345
Worcester, Massachusetts 01608

Dear Mr. Briggs:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General final report entitled "Review of Personal Care Services Claimed by the Center for Living and Working, Inc." 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through e-mail at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-06-00011 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Richard McGreal
Associate Regional Administrator for Medicaid
Division of Financial Management and Fee for Service Operations
Centers for Medicare & Medicaid Services – Region I
U.S. Department of Health and Human Services
JFK Federal Building – Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PERSONAL CARE SERVICES CLAIMED BY THE CENTER FOR LIVING AND WORKING, INC.

Daniel R. Levinson
Inspector General

October 2007
A-01-06-00011

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS 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 pays medical assistance costs for persons with limited income and resources. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare and Medicaid Services to ensure compliance with Federal requirements. In Massachusetts, the Executive Office of Health and Human Services (the State agency) administers the Medicaid program.

Medicaid provides reimbursement for personal care services to help people with long-term disabilities live at home independently. Specifically, personal care services assist people with activities of daily living (e.g., taking medications, bathing, dressing, eating, using the toilet) and instrumental activities of daily living (e.g., preparing meals, doing housework, shopping, traveling to medical providers).

The State agency contracts with various nonprofit agencies to provide personal care services. Medicaid reimburses these nonprofit agencies for each service provided to a beneficiary. Most of the dollars reimbursed by Medicaid are based on the number of hours of services that the beneficiary receives.

The State agency had a contract with The Center for Living and Working, Inc., (the Center) to provide fiscal intermediary services beginning in 1998 and personal care services beginning in 2002. The State agency terminated its fiscal intermediary contract with the Center in December 2005.

OBJECTIVE

Our objective was to determine whether the Center claimed personal care services in accordance with Medicaid rules and regulations.

SUMMARY OF FINDINGS

The Center did not always claim personal care services in accordance with Medicaid rules and regulations from October 1, 2003 through September 30, 2005. From our sample of reimbursed claims for 100 beneficiary payment years, we found errors totaling $20,552 ($10,704 Federal share) for services that were provided by personal care attendants on dates when the beneficiaries were hospital inpatients and for services that were either insufficiently documented or unauthorized. Based on the sample results, we estimate that the Center received overpayments of $493,777 ($256,366 Federal share). We attribute these errors to the Center's lack of sufficient procedures to ensure that it claimed reimbursement for services in accordance with Medicaid rules and regulations.

RECOMMENDATIONS

We recommend that the Center:

- refund to the State agency $493,777 ($256,366 Federal share) and

- strengthen procedures to ensure that it claims PCA services in accordance with Medicaid rules and regulations.

THE CENTER FOR LIVING AND WORKING, INC.'S, COMMENTS

In its comments on our draft report, the Center disagreed in part with our findings and recommendations. Specifically, the Center stated that our draft report misconstrued the sources and amount of the payment errors.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We maintain that our findings and recommendations are correct and need no modification.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance costs 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.

Personal Care Services

Medicaid provides reimbursement for personal care services to help beneficiaries with long-term disabilities live at home independently. Specifically, personal care services assist people with activities of daily living (e.g., taking medications, bathing, dressing, eating, using the toilet) and instrumental activities of daily living (e.g., preparing meals, doing housework, shopping, traveling to medical providers.

The Massachusetts Executive Office of Health and Human Services

In Massachusetts, the Executive Office of Health and Human Services (the State agency) administers the Medicaid program. The responsibilities of the State agency include processing claims and monitoring provider operations. On a quarterly basis, the State agency submits Form CMS-64 to summarize, by category of service, Medicaid expenditures for Federal reimbursement.

The State agency contracts with various nonprofit agencies to provide personal care services. Medicaid reimburses these nonprofit agencies for each service provided to a beneficiary. Most of the dollars that Medicaid reimburses are based on the number of hours of services that the beneficiary receives.

The Center for Living and Working, Inc.

The Center for Living and Working, Inc., (the Center) in Worcester, Massachusetts, was founded in 1975. It provides advocacy, personal care management, and deaf and hard-of-hearing services to persons with disabilities to assist them in living independently. The State agency had a contract with the Center to provide fiscal intermediary services beginning in 1998 and personal care services beginning in 2002. The State agency terminated its fiscal intermediary contract with the Center in December 2005.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Center claimed personal care services in accordance with Medicaid rules and regulations.

Scope

We reviewed personal care services that the Center claimed from October 1, 2003, through September 30, 2005. The Center processed personal care service claims totaling $78,606,130 for 4,466 beneficiary payment years[1] during this period.

We limited consideration of the Center's internal control structure to those controls concerning personal care claims processing because the objective of our review did not require an understanding or assessment of the complete internal control structure. Further, we concluded that our review of the internal control structure could be conducted more efficiently by substantive testing.

We performed our field work at the Center in Worcester, Massachusetts, from November 2006 through April 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements regarding Medicaid reimbursement for personal care services;

- interviewed State and Center officials;

- reviewed the State agency's contract with the Center for providing personal care services;

- compiled a file of the Center's claims for personal care services provided from October 1, 2003, through September 30, 2005, from the CMS Medicaid Statistical Information System;

- selected a random sample of 50 beneficiary payment years in Federal fiscal year 2004 and 50 in 2005 (see Appendix A);

- reviewed documentation, including consumer profiles, prior authorizations, evaluations, and timesheets, supporting all personal care services that the Center

[1]A beneficiary payment year comprises all of the services claimed for a beneficiary during a 12-month period.

provided to 99 beneficiaries in the 100 randomly selected beneficiary payment years and billed to Medicaid; and

- used a stratified variable appraisal program to estimate the total dollar value of inappropriately claimed personal care services (see Appendix B).

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The Center did not always claim personal care services in accordance with Medicaid rules and regulations from October 1, 2003, through September 30, 2005. From our sample of reimbursed claims for 100 beneficiary payment years, we found errors totaling $20,552 ($10,704 Federal share) for services that were provided by personal care attendants on dates when the beneficiaries were hospital inpatients and for services that were either insufficiently documented or unauthorized. Based on the sample results, we estimate that the Center received overpayments of $493,777 ($256,366 Federal share) during the audit period. We attribute these errors to the Center's lack of sufficient procedures to ensure that it claimed reimbursement for services in accordance with Medicaid rules and regulations.

FEDERAL AND STATE REQUIREMENTS

Federal Law

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

State Regulations

Commonwealth of Massachusetts Program Regulations (130 CMR 450.235(E)) state that "Overpayments include, but are not limited to, payments to a provider . . . for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts.

130 CMR 422.419(B) further states: "The fiscal intermediary must fulfill its responsibility in accordance with its contract with the Division."

INCORRECTLY CLAIMED PERSONAL CARE SERVICES

Services Claimed for Beneficiaries During Inpatient Stays

Based on our sample of 100 beneficiary payment years, the Center was reimbursed $2,499 ($1,298 Federal share) for services that were provided by personal care attendants on dates when the beneficiaries were hospital inpatients. For example, Beneficiary A was a hospital inpatient from February 1 to February 8, 2005. Contrary to Federal requirements, the Center received reimbursement totaling $468 ($234 Federal share) for services for Beneficiary A on February 2 through February 7, 2005.

Services Insufficiently Documented or Unauthorized

Based on our sample of 100 beneficiary payment years, the Center was reimbursed $18,053 ($9,406 Federal share) for services that were either insufficiently documented or unauthorized. These errors included personal care attendant timesheets that were missing or contained mathematical errors. For example, during 1 beneficiary payment year, the Center received reimbursement for three claims totaling $1,758 ($931 Federal share) for which the Center had no activity forms (timesheets).

ESTIMATED OVERPAYMENTS

Based on the results of our sample, we estimate that the Center received overpayments totaling $493,777 ($256,366 Federal share) from October 2003 through September 2005 (see Appendix B).

CAUSE OF OVERPAYMENTS

We attribute these overpayments to the Center's lack of sufficient procedures to ensure that the Center claimed reimbursement for services in accordance with Medicaid requirements.

RECOMMENDATIONS

We recommend that the Center:

- refund to the State agency $493,777 ($256,366 Federal share) and

- strengthen procedures to ensure that it claims PCA services in accordance with Medicaid rules and regulations.

THE CENTER FOR LIVING AND WORKING, INC.'S, COMMENTS

In its comments on our draft report, the Center disagreed in part with our findings and recommendations.

The Center stated that our draft report reflected a misunderstanding of the services that it provided to the State agency. The Center pointed out that it had contracts for two kinds of Medicaid services: 1) direct personal care management services provided by the Center's employees and 2) fiscal intermediary services for which the Center served as the intermediary between Medicaid beneficiaries and the personal care attendants whom the beneficiaries employed. The Center asserted that, of the $493,777 projected value of erroneous claims, only $19,629 related to personal care management services provided by the Center's employees.

In response to our finding that the Center claimed services for beneficiaries during inpatient stays, the Center acknowledged that its fiscal intermediary had relied on timesheets to make payments to the personal care attendants of beneficiaries who were hospitalized or had died. However, the Center maintained that we should have recognized that the fiscal intermediary had no mechanism for determining that such a hospitalization or death had occurred without delaying payment to the personal care attendant. The Center noted that late payments could cause the personal care attendant to seek other employment, leaving the beneficiary without the assistance required for remaining independent. For this reason, the Center requested that we remove the $60,000 associated with these errors from the projected value of erroneous claims.

In response to our finding that the Center claimed services that were unauthorized or undocumented, the Center stated that the fiscal intermediary's staff generally attempted to contact beneficiaries whose timesheets were incomplete or contained errors, but that, in the absence of a timely response, the staff paid the invoice as long as the beneficiary was covered for the service claimed.

The Center stated that it was working with the State agency to strengthen its procedures for ensuring that its claims were in accord with Medicaid rules and regulations, as recommended in our draft report. The Center further noted that most of the errors that we noted were attributable to its fiscal intermediary and that it had terminated its fiscal intermediary in 2005.

The Center's comments are presented in their entirety in Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We maintain that our original conclusions as stated in the draft report are correct and need no modification. Federal law clearly precludes payment for personal care services provided to hospital inpatients. Pursuant to its contract with the State agency, the Center operated as both fiscal intermediary and PCA during the audit period. Accordingly, the Center was responsible for ensuring that its fiscal intermediary did not make payments for personal care services provided to hospital inpatients. The Center and its fiscal intermediary could have avoided most of these errors by developing an adequate system of internal controls that included a simple periodic inquiry to the Center's Medicaid beneficiaries regarding any inpatient stays that they may have had.

We also stand by our original conclusion that the Center was reimbursed $18,053 ($9,406 Federal share) for services that were either insufficiently documented or unauthorized. The Center's comments on our draft report did not provide any additional documentation that supported the Center's claim for reimbursement of these services.

We commend the Center for its work with the State agency in strengthening its internal controls and encourage the Center to continue to do so.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether the Center claimed personal care services in accordance with Medicaid rules and regulations from October 2003 through September 2005

POPULATION

The population consisted of 4,466 beneficiary payment years containing 138,831 paid services that were provided from October 1, 2003, through September 30, 2005.

SAMPLE DESIGN

We designed a stratified random sample consisting of two strata. The first stratum consisted of 2,188 beneficiary payment years containing 69,289 services provided during 2004. The second stratum consisted of 2,278 beneficiary payment years containing 69,542 services provided during 2005.

Stratum Number	Description of Stratum	Number of Population Claims	Payment Amounts
1	FY 2004	2,188	$39,055,532
2	FY 2005	2,278	$39,550,598
		4,466	**$78,606,130**

SAMPLE SIZE

The sample consisted of 100 beneficiary payment years (50 from each stratum) containing 3,737 services totaling $1,698,353.

APPENDIX B

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
1 – FY 2004	50	$868,336	25	$15,135
2 – FY 2005	50	$827,017	17	$5,417
Total	**100**	**$1,698,353**	**42**	**$20,552**

VARIABLE PROJECTIONS

	Projected Value of Erroneous Claims
Point Estimate	$909,099
90-percent confidence level	
Lower limit	$493,777
Upper limit	$1,324,421
Precision	+/- 46 percent

CENTER FOR LIVING AND WORKING, INC.
CORPORATE AND ADMINISTRATIVE OFFICES
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September 7, 2007

VIA Fax (617) 565-2690 and First Class Mail

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Center for Living and Working
Report A-01-06-00011

The Center for Living and Working, Inc. ("CLW") has received the U.S. Dept. of Health and Human Services, Office of Inspector General's draft report entitled "Review of Personal Care Services Claimed by the Center for Living and Working, Inc. from October 1, 2003 through September 30, 2005" (the "Draft"). Your cover letter requests that we provide your office written comments on the Draft, regarding the validity of the facts on which you rely and the reasonableness of your recommendations as well as a report on the status of action we have or intend to take in response to those recommendations.

VALIDITY OF THE FACTS

In one important respect, we believe that the Draft reflects a misunderstanding of the services provided by CLW to the State agency. During the period under audit, CLW had contracts for two kinds of Medicaid services: (1) direct personal care management services, where CLW employees provided services such as evaluations and training of Medicaid beneficiaries and Prior Approvals and (2) fiscal intermediary ("FI") services where CLW served as the intermediary between a Medicaid beneficiary who, for purposes of the State program, was a direct employer of a personal care assistant (a "PCA") who was as, a legal matter, the employee of the Medicaid beneficiary. Of the $493,777 projected value of erroneous claims, only $19,629 related to personal care management services provided by the employees of CLW. This is not to minimize the failings in the FI program, but to point out the error in describing the sources of the erroneous payments.

Next, it is a fact that CLW's FI relied on submitted timesheets to make payments on behalf of Medicaid beneficiaries to their PCAs when the Medicaid beneficiary was hospitalized or had died. The audit should have recognized that there is no mechanism whereby the FI could determine that such a hospitalization or death had occurred and still make a timely payment to the PCA. Timely payments for PCA services are essential to the success of this program because late payments may mean that the PCA will seek other employment and the Medicaid beneficiary will be left without the assistance he or she needs to remain independent. Because the FI did not

have the capacity to determine the facts that would have led it to withhold payment, the amounts charged against us for these errors, approximately $60,000, should be removed projected value of the erroneous claims.

Finally, I want to take the opportunity to explain, at least partially, why payments for Medicaid beneficiaries to their PCAs were made in the face of timesheet errors. It is our understanding that the FI put service to these Medicaid beneficiaries as its highest priority. So, when a timesheet came in that was incomplete or contained errors, the FI staff attempted to contact the beneficiary to correct any error, but, in the absence of a timely response, it paid the invoice so long as the Medicaid beneficiary's account, the "Prior Approval," was sufficient to cover the reported hours of service on the time sheet.

RESPONSE TO THE RECOMMENDATIONS

The Draft recommends that CLW strengthen its procedures to ensure that claims are in accord with Medicaid rules and regulations. We are in the process of doing so in close cooperation with the State agency.

With respect to the FI, our board and senior management recognized that the FI had operational problems and that attention to those problems diverted our focus from the high quality core services on which we had built our reputation. We terminated the FI in 2005. As noted above, it was the FI that accounted for almost the entire sum of the errors your team discovered.

Thank you for this opportunity to comment on the Draft. If you would like to discuss any of these comments, please contact me by phone during business hours at 508.926.3466 or by email at tbriggs@bowditch.com.

Sincerely yours,

Terrence J. Briggs,
President, Board of Directors