DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 7, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health (A-06-09-00062)

Attached, for your information, is an advance copy of our final report on New Mexico Medicaid personal care services provided by Ambercare Home Health. We will issue this report to the New Mexico Human Services Department, Medical Assistance Division, 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 Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00062.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VI
1100 COMMERCE STREET, ROOM 632
DALLAS, TX 75242

March 12, 2012

Report Number: A-06-09-00062

Ms. Julie B. Weinberg
Director, Medical Assistance Division
New Mexico Human Services Department
2025 South Pacheco
Santa Fe, NM 87504

Dear Ms. Weinberg:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health*. 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 at (214) 767-8414, or contact Paul Garcia, Audit Manager, at (512) 339-3071 or through email at Paul.Garcia@oig.hhs.gov. Please refer to report number A-06-09-00062 in all correspondence.

Sincerely,

/Patricia Wheeler/
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 and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW MEXICO MEDICAID PERSONAL CARE SERVICES PROVIDED BY AMBERCARE HOME HEALTH

Daniel R. Levinson
Inspector General

March 2011
A-06-09-00062

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 and 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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THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

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 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 New Mexico, the Human Services Department, Medical Assistance Division (the State agency), is responsible for administering the Medicaid program.

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 disease. 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 and, at the State agency's option, at another location. Examples of personal care services include, but are not limited to, cleaning, shopping, grooming, and bathing.

The State agency contracts with a third-party assessor to perform an in-home assessment of each recipient that determines the types and amounts of care needed and to develop a personal care service plan. In addition, New Mexico law requires a supervisor from the personal care services provider agency to visit each recipient or his/her personal representative in the recipient's home monthly. The State agency periodically reviews provider agencies to ensure compliance with Federal and State requirements.

The State agency reported to CMS personal care services expenditures of approximately $433 million ($309 million Federal share) from October 1, 2006, through September 30, 2008. Of that amount, Ambercare Home Health (Ambercare), a personal care services provider in Belen, New Mexico, received $33,769,207 ($24,132,420 Federal share).

OBJECTIVE

Our objective was to determine whether the State agency ensured that Ambercare's claims for reimbursement of Medicaid personal care services complied with certain Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always ensure that Ambercare's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 claims in our sample, 77 (totaling $86,192) complied with requirements, but 23 (totaling $25,380) did not. Thirteen of

the twenty-three claims were partially allowable. The allowable portion of the 13 claims was $16,337. Those 23 claims contained a total of 24 deficiencies: 7 deficiencies on insufficient attendant qualifications and 17 deficiencies on other issues. As a result, Ambercare improperly claimed $9,043 for the 23 claims.

Based on our sample results, we estimated that Ambercare improperly claimed at least $888,683 (Federal share) for personal care services during the period October 1, 2006, through September 30, 2008.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $888,683 paid to Ambercare for unallowable personal care services and

- ensure that personal care services providers maintain evidence that they comply with Federal and State requirements.

AMBERCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Ambercare disagreed with our findings on billing records. Ambercare stated that it "offered several remedies to the auditor for his consideration, and were denied that opportunity" and that it "found an incorrect billing total of $218.55 compared to the audit findings." Ambercare's comments are included as Appendix D. We excluded the attachments to Ambercare's comments because they contained personally identifiable information.

We disagree that we denied Ambercare the opportunity to provide remedies for our findings. During our review, we met with Ambercare officials at Ambercare's main office in Belen, New Mexico, on several occasions to discuss our preliminary findings, consider Ambercare's views, and review its supporting documentation. Moreover, we reviewed the attachments that Ambercare provided with its comments. Based on the new documentation, we determined that 14 additional claims were allowable. We revised the findings and recommendations accordingly.

We also disagree with Ambercare's conclusion that it owes only $218.55 for our sampled claims. We analyzed the documentation provided by Ambercare in accordance with generally accepted government auditing standards and stand by our reported findings and recommendations.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, the State agency said that it generally agreed with our findings for the specific claims reviewed. However, the State agency disagreed with our recommended refund amount paid to Ambercare for improper claims submitted for the audit period. The State agency said that four categories of deficiencies (i.e., training documentation,

prior approval of legal guardian, cardiopulmonary resuscitation certification, and physician authorization) did not justify withholding Federal funds because only a small number of files were deficient. The State agency also said that the documentation requirements for three of the four categories (i.e., training documentation, prior approval of legal guardian, and CPR certification) are not Federal requirements; they are State requirements, which do not require recovery of payments. The State agency added that although two categories of deficiencies (i.e., an unsupported number of units claimed and services paid while the recipient was in the hospital) support the conclusion that overpayments were made, the deficiencies did not support extrapolating to the population because (1) the findings do not reveal a pattern of noncompliance and (2) the percentage of claims that were overpayments was within the tolerance limits established by certain Federal programs.

The State agency's comments are included in their entirety as Appendix E.

We stand by our reported findings and recommendations. The deficiencies cited in the report are based on significant service-related requirements and are too numerous to be dismissed as infrequent occurrences. Further, Federal requirements are applicable to the three categories with documentation deficiencies because to be considered qualified as defined by Federal statutes and regulations, attendants must meet State attendant requirements.

Regarding the State agency's assertion that the findings do not reveal a pattern of noncompliance, extrapolating the results of a statistically valid sample to a population has a high degree of probability of being close to the results of a 100-percent review of the same population. Our statistically valid estimates support our findings and estimated overpayment amount.

Finally**,** pursuant to the Inspector General Act of 1978, 5 U.S.C. App., our audits are intended to provide an independent assessment of U.S. Department of Health and Human Services programs, operations, grantees, and contractors. The tolerance limits the State agency cited in its comments about certain Federal programs do not apply to our audits.

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INTRODUCTION

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 New Mexico, the Human Services Department, Medical Assistance Division (the State agency), is responsible for administering the Medicaid program.

New Mexico's Personal Care Services Program

The New Mexico personal care services program provides a wide range of services for the elderly and individuals with a qualifying disability. The goal of the program is to improve recipients' quality of life and prevent them from having to enter a nursing facility. The State agency requires recipients to obtain a physician authorization form that documents the medical need for personal care services. For each recipient, the State agency contracts with a third-party assessor that performs an in-home assessment to determine the types and amounts of care needed and to develop a personal care services plan (PCSP). The third-party assessor uses recipient assessments and physician authorization forms to prepare recipients' weekly schedule of services, which typically are in effect for 1 year.

Federal and State Requirements

The State agency must comply with Federal and State requirements when determining and redetermining whether recipients 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 disease. The services must be (1) authorized for an individual 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; (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 and, at the State agency's option, at another location.

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. Circular A-87, Attachment A, section C.1.c., states that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

New Mexico Administrative Code (NMAC) section 8.315.4.9(A) states that personal care services are delivered pursuant to a PCSP and (1) include a range of services to recipients who

are unable to perform some or all activities of daily living because of a disability or functional limitation(s); (2) permit an individual to live in his or her home rather than an institution and to maintain or increase independence; and (3) include, but are not limited to, bathing, dressing, grooming, eating, and shopping.

NMAC section 8.315.4.11A(17) states that provider agencies are responsible for maintaining appropriate records of services provided to recipients. NMAC section 8.315.4.11 defines (1) attendant qualifications related to tests for tuberculosis, annual training, cardiopulmonary resuscitation (CPR) and first aid training, and criminal background checks and (2) the provider agency's responsibility to maintain documentation on attendant qualifications. NMAC section 8.315.4.11A(31) requires provider agencies to conduct a monthly supervisory visit with each recipient or his or her personal representative in the recipient's home. The State agency periodically reviews personal care services provider agencies to ensure their compliance with Federal and State requirements. NMAC section 8.315.4.11A(21) requires the State agency to review a written justification for, and issue an approval of, instances in which any personal care services will be provided by the recipient's legal guardian or attorney-in-fact.

Personal Care Services Expenditures

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 New Mexico was 71.93 percent; from October 1, 2007, through September 30, 2008, the FMAP was 71.04 percent. The State agency reported to CMS personal care services expenditures of approximately $433 million ($309 million Federal share) from October 1, 2006, through September 30, 2008. Of that amount, Ambercare Home Health (Ambercare), a personal care services provider in Belen, New Mexico, received $33,769,207 ($24,132,420 Federal share).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency ensured that Ambercare's claims for reimbursement of Medicaid personal care services complied with certain Federal and State requirements.

Scope

This audit covered the $33,769,207 the State agency paid to Ambercare for 29,855 claim lines (hereafter referred to as "claims") paid from October 1, 2006, through September 30, 2008. We limited our review of internal controls to the State agency's oversight of personal care services providers and Ambercare's procedures for maintaining documentation related to attendants and recipients.

We conducted our fieldwork at the State agency office in Santa Fe, New Mexico; the third-party assessor's office in Albuquerque, New Mexico; and the Ambercare office in Belen, New Mexico.

Methodology

To accomplish our objective, we:

- reviewed Federal requirements for the Medicaid personal care services program;
- reviewed State documents for the personal care services program: the New Mexico State plan amendment (Attachment 3.1-A, effective September 1, 2000) and the NMAC;
- interviewed State agency officials to gain an understanding of the personal care services program and the State agency reviews completed before the start of our fieldwork;
- obtained from the State agency all claims data for personal care services that were paid from October 1, 2006, through September 30, 2008, and reconciled the totals to the amounts claimed during the same period on the Form CMS-64**,** Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program;
- totaled the paid-claims data by provider;
- selected Ambercare to review based on payment for personal care services claims it received totaling $33,769,207 for the audit period;
- selected a random sample of 100 Ambercare claims (Appendix A);
- met with Ambercare officials to gain an understanding of Ambercare's policies and procedures and of documentation in Ambercare's recipient and attendant personnel files;
- obtained recipient documentation from the third-party assessor and Ambercare for each sampled item;
- identified the attendant(s) included in each sampled claim and obtained documentation Ambercare maintained in the identified attendant personnel files;
- obtained from the New Mexico Department of Health documentation of criminal background checks on the identified attendants;
- evaluated the documentation obtained for each sampled item to determine whether it complied with Federal and State Medicaid requirements;
- discussed the results of our audit with officials from CMS, the State agency, and Ambercare;

- gave Ambercare an opportunity to provide any additional support for claims with deficiencies;

- calculated the value of the unallowable reimbursement Ambercare received for the sampled claims; and

- estimated the unallowable Federal Medicaid reimbursement paid for the 29,855 claims (Appendix B).

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.

FINDINGS AND RECOMMENDATIONS

The State agency did not always ensure that Ambercare's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 sampled claims, 77 claims (totaling $86,192) complied with requirements, but 23 (totaling $25,380) did not. Thirteen of the twenty-three claims were partially allowable. The allowable portion of the 13 claims was $16,337. Those 23 claims contained a total of 24 deficiencies: 7 deficiencies on insufficient attendant qualifications and 17 deficiencies on other issues. As a result, Ambercare improperly claimed $9,043 for the 23 sampled claims.

See Appendix C for details of the deficiencies identified by sampled claim.

Based on our sample results, we estimated that Ambercare improperly claimed at least $888,683 (Federal share) for personal care services during the period October 1, 2006, through September 30, 2008.

ATTENDANT QUALIFICATION DEFICIENCIES

Annual Training

NMAC section 8.315.4.11A(2) requires provider agencies to provide all attendants a minimum of 12 hours of training per year; section 8.315.4.11A(33) requires provider agencies to maintain in attendants' files copies of documentation that all training had been completed. For 6 of the 100 sampled claims, Ambercare could not provide evidence that the attendants had completed 12 hours of annual training for the calendar year of the dates of service.

Cardiopulmonary Resuscitation Certification

NMAC section 8.315.4.11A(2)(d) requires provider agencies to maintain in attendant files copies of all CPR certifications and to ensure that these certifications are current.[1] For 1 of the 100 sampled claims, Ambercare could not provide evidence that the attendant was certified in CPR on the dates of service.

OTHER DEFECIENCIES

Unsupported Units Claimed

NMAC section 8.315.4.11A(13) requires provider agencies to maintain records that fully disclose the extent and nature of the services furnished to the recipient. For 13 of the 100 sampled claims, Ambercare did not have evidence to support the number of units claimed for attendant services.

Missing Prior Approval for Personal Care Services Provided by a Legal Guardian or Attorney-in-Fact

NMAC section 8.315.4.11A(21) requires prior State agency approval for any personal care services provided by the recipient's legal guardian or attorney-in-fact. For 2 of the 100 sampled claims, Ambercare could not provide evidence that the State agency issued prior approval.

Personal Care Services Paid for Dates Recipient Was in the Hospital

Federal regulations (42 CFR § 440.167) and NMAC section 8.315.4.13B prohibit payment for personal care services provided for recipients in a hospital. For 1 of the 100 sampled claims, Ambercare was paid for personal care services for dates the recipient was in a hospital.

Physician Authorization

Federal regulations (42 CFR § 440.167) require personal care services to 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. Also, NMAC section 8.315.4.16A(1) requires third-party assessors or their designees to maintain for each recipient evidence of a physician authorization form signed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist. For 1 of the 100 sampled claims, Ambercare could not provide documentation of a physician authorization.

EFFECT OF DEFICIENCIES

Based on our sample, we estimated that Ambercare improperly claimed at least $888,683 (Federal share) for personal care services.

[1] The entities that provided the training determined how long the certificates were valid, typically 1 to 3 years from the date the attendants passed the courses.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $888,683 paid to Ambercare for unallowable personal care services and

- ensure that personal care services providers maintain evidence that they comply with Federal and State requirements.

AMBERCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Ambercare disagreed with our findings as far as billing records are concerned. Ambercare stated that it "offered several remedies to the auditor for his consideration, and were denied that opportunity." Ambercare also stated that it had "compared our records with the State of New Mexico Portal billing entries and found an incorrect billing total of $218.55 compared to the audit findings." Ambercare's comments are included as Appendix D. We excluded the attachments because they contained personally identifiable information.

We disagree that we denied Ambercare the opportunity to provide remedies for our findings. During our review, we met with Ambercare officials at Ambercare's main office in Belen, New Mexico, on several occasions to discuss our preliminary findings, consider Ambercare's views, and review its supporting documentation. Moreover, we reviewed the attachments that Ambercare provided with its comments. Based on the new documentation that Ambercare provided, we determined that 14 claims were allowable. We revised the findings and recommendations accordingly.

We also disagree with Ambercare's conclusion that it owes only $218.55 for our sampled claims. We analyzed the documentation provided by Ambercare in accordance with generally accepted government auditing standards and stand by our reported findings and conclusions.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In its written comments on our draft report, the State agency said that it generally agreed with our findings for the specific claims reviewed but disagreed that our findings support the recommended refund amount.

The State agency said that four categories of deficiencies (i.e., training documentation, prior approval of legal guardian, CPR certification, and physician authorization) involved no demonstrated overpayments and that the deficiencies did not justify withholding Federal funds. Rather, the findings revealed that a few files were missing a document necessary to satisfy a

particular requirement for otherwise eligible services. The State agency also said that the documentation requirements in question for three of the four categories (i.e., training documentation, prior approval of legal guardian, and CPR certification) are not Federal requirements; they are State requirements, which do not require recovery of payments.

The State agency agreed that although two categories of deficiencies (i.e., an unsupported number of units claimed and services paid while the recipient was in the hospital) support the conclusion that overpayments were made, these deficiencies do not support extrapolating the overpayments to all claims submitted during the 2-year review period. The State agency added that the existence of one claim that was erroneously paid for services provided while the recipient was in the hospital is not a sufficient basis on which to extrapolate to the population. The State agency said that this incident appears to have been isolated and that it does not reflect a pattern or practice of noncompliance by Ambercare. The State agency said that because these overpayments were less than 2 percent of all payments reviewed, they were within tolerance limits established in certain Federal programs and that standard Federal policy in such circumstances is to seek recovery only for the overpayments identified and not to extrapolate the results.[2]

The State agency's comments are included in their entirety as Appendix E.

Office of Inspector General Response

The deficiencies cited in the report, including annual service-related training, prior approval of legal guardianship, CPR training, and physician authorization, are based on significant service-related requirements. Taken as a whole, these deficiencies are too numerous to be dismissed as just a few missing files, particularly when the deficiencies in question are related to quality-of-care issues.

We disagree that the documentation requirements in question for three of the four categories the State agency mentioned above were not Federal requirements. To provide a valid and payable service, personal care services must meet Federal requirements in section 1905(a)(24)(B) of the Act and implementing regulations at 42 CFR § 440.167, which require personal care services to be provided by a qualified individual. To be qualified in New Mexico, an attendant must meet the NMAC requirements related to the attendant qualifications discussed above. Therefore, an attendant who does not meet the NMAC attendant qualification requirements cannot provide valid personal care services as defined by Federal statutes and regulations. We based other determinations of deficiencies on regulatory requirements that are integral to the definition of personal care services and that must be met for the services to be payable as medical assistance.

The methodology we used to select the sample and the methodology we used to evaluate the results of that sample have resulted in an unbiased extrapolation (estimate) of Ambercare's personal care services. As stated in New York State Department of Social Services, DAB 1358 (1992), "… sampling (and extrapolation from a sample) done in accordance with scientifically

[2] The State agency cited 42 CFR § 431.865 (which establishes a 3-percent tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control Program) and 45 CFR § 205.42 (1980) (an outdated regulation that established a 4-percent tolerance limit for payment errors in the Aid to Families with Dependent Children program).

accepted rules and conventions has a high degree of probability of being close to the finding which would have resulted from individual consideration of numerous cost items and, indeed, may be even more accurate, since clerical and other errors can reduce the accuracy of a 100% review."

The Ambercare sample was selected according to principles of probability (every sampling unit has a known, nonzero chance of selection). In *Sample Design in Business Research,* W. Edwards Deming (1960) states: "An estimate made from a sample is valid if it is unbiased or nearly so and if we can compute its margin of sampling error for a given probability."

The validity of the use of sampling and extrapolation as part of audits in connection with Federal health programs has long been approved by courts. [3] In particular, "[p]rojection of the nature of a large population through review of a relatively small number of its components has been recognized as a valid audit technique."[4] Courts have not determined how large a percentage of the entire universe must be sampled in order to be held valid;[5] however, the type of sample used here—a simple random sample—is recognized as a valid type of collection for extrapolation purposes.[6] Further, such statistical sampling and such a methodology may be used in cases seeking recovery against States and individual providers or private institutions alike.[7]

Pursuant to the Inspector General Act of 1978, 5 U.S.C. App., our audits are intended to provide an independent assessment of U.S. Department of Health and Human Services programs, operations, grantees, and contractors. Therefore, the payment error tolerance limits that the State agency cited for the Medicaid Eligibility Quality Control program and the Aid to Families with Dependent Children program do not apply to our audits.

We did not change our recommendations in response to the State agency's comments. However, we changed the estimated overpayment and recommended recovery, which were incorrect in the draft report.

[3] See, e.g., *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409-410 (N.D.Ga. 1977) (ruling that sampling and extrapolation are recognized as valid audit techniques for programs under Title IV of the Act); *Ratanasen* v. *California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993) (ruling that simple random sampling and subsequent extrapolation were valid techniques to calculate Medi-Cal overpayments); *Illinois Physicians Union* v. *Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982) (ruling that random sampling and extrapolation were valid statistical techniques to calculate Medicaid overpayments claimed against an individual physician).

[4] *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409 (N.D.Ga. 1977).

[5] *Michigan Department of Education* v. *U.S. Department of Education*, 875 F. 2d 1196, 1206 (6th Cir. 1989).

[6] *Ratanasen* v. *California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993).

[7] *Illinois Physicians Union* v. *Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982).

OTHER MATTERS

MEAL PREPARATION AND HOUSEKEEPING SERVICES PAID FOR RECIPIENTS LIVING WITH ATTENDANTS

In reviewing supporting documentation for 47 of the 100 sampled claims, we found that $17,755 was charged for attendants' meal preparation and housekeeping services even though the attendants and recipients lived in the same home. The State agency paid a standard rate for each unit of time charged for attendant care regardless of whether the attendant and recipient lived in the same home. During the scope of this audit, there were no Federal or State regulations addressing payment for services provided by an attendant who lives with the recipient.

The State has since amended its regulations (NMAC sections 8.315.4.16 and 17) to exclude personal care attendant services that are normal household chores and that are provided by a person who resides with the beneficiary.

ATTENDANT CHARGED SAME TIME FOR TWO RECIPIENTS

We identified two claims in which the attendant had documented simultaneously performing services for two recipients who lived in the same household. The State agency paid a standard rate for each unit of time charged for attendant care for each recipient. Although there are no Federal or State regulations addressing whether attendants may charge for services provided simultaneously to more than one recipient, paying twice for the same unit of time may not always be reasonable.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of personal care services claim lines submitted by Ambercare Home Health (Ambercare) for Federal Medicaid reimbursement by New Mexico for the 2-year period October 1, 2006, through September 30, 2008. A claim line represented unit(s) of service paid (0.25 hour equaled 1 unit of service).

SAMPLING FRAME

The sampling frame consisted of 29,855 personal care services claim lines (totaling $33,769,207) from October 1, 2006, through September 30, 2008.

SAMPLE UNIT

The sample unit was a personal care services claim line for which New Mexico reimbursed Ambercare.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame from 1 to 29,855. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used Office of Inspector General, Office of Audit Services, statistical software to estimate the total value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sampling Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Claim Lines With Deficiencies	Value of Claim Lines With Deficiencies (Federal Share)
29,855	$24,132,420	100	$79,847	23	$6,460

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)
(Federal Share)

Point estimate	$1,928,633
Lower limit	$888,683
Upper limit	$2,968,583

APPENDIX C: REASONS FOR DEFICIENT CLAIM LINES

1	Missing Evidence of Annual Training
2	Missing Evidence of Cardiopulmonary Resuscitation Certification
3	Unsupported Units of Payment
4	Missing Evidence of Prior State Agency Approval for Personal Care Services Provided by Recipient's Legal Guardian or Attorney-in-Fact
5	Services Paid for Dates Recipient Was in Hospital
6	Missing Evidence of Physician Authorization

No.	1	2	3	4	5	6	No. of Deficiencies	Sample Item No.[1]
1			X				1	4
2					X		1	5
3	X						1	6
4			X				1	8
5	X						1	11
6			X				1	12
7				X			1	17
8		X					1	22
9	X		X				2	49
10						X	1	54
11	X						1	55
12	X						1	58
13				X			1	63
14			X				1	64
15			X				1	68
16			X				1	73
17			X				1	84
18			X				1	85
19	X						1	91
20			X				1	92
21			X				1	93
22			X				1	96
23			X				1	99
Total	**6**	**1**	**13**	**2**	**1**	**1**	**24**	

Total deficiencies for "Attendant Qualification Deficiencies" (columns 1 and 2) is 7.
The total for "Other Deficiencies" (columns 3 through 6) is 17.

[1] We include the "Sample Item No." column as a cross-reference to the specific sample item.

APPENDIX D: AMBERCARE COMMENTS

AMBERCARE® HOME HEALTH

P.O. BOX 1610
420 North Main
Belen, New Mexico 87002

Telephone (505) 861-0060
Fax (505) 861-0045

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas TX, 75242

Report # A-06-09-00062

August 20, 2010

Dear Ms. Wheeler:

Ambercare is an Employee Stock Owned Corporation. 85 % of the owners are women and 70 % are Hispanic. We take pride in many things about our organization two of which are excellent patient care and careful record keeping.

We have spent hours reviewing the draft audit we received from your office on July 30, 2010 and have found significant inconsistencies with your data and our data. At the time of the audit, we offered several remedies to the auditor for his consideration, and were denied that opportunity. We have since then located documents that were misfiled and stored in a facility. For example: in the last four years we have had eight different CPR instructors who have filed documents for Ambercare caregivers individually, and not uniformly. The audit brought this inconsistency to our attention. All records have been located and are now filed in a uniform fashion.

We strongly disagree with the audit findings as far as billing records are concerned. We have compared our records with the State of New Mexico Portal billing entries and found an incorrect billing total of $218.55 compared to the audit findings. For your information we have enclosed a line by line refutation of the audit findings.

Also for your information we are enclosing our most recent State of New Mexico surveys and a Personal Care Option Program survey dated October 14, 2008. All of these surveys show no deficiencies and therefore no corrective action necessary. With these results, you may be able to understand our puzzlement as to the auditor's findings.

Ambercare was contacted on August 10, 2010 by the Executive Director of the New Mexico Home Care and Hospice Association urging us to join with the other agencies audited by you in beginning legal action. We declined this offer and believe that if you take a closer look at our findings, you will see that our records are correct and complete.

Sincerely,

Mary E. Merrell

Mary E. Merrell RN
Executive Director

APPENDIX E: NEW MEXICO HUMAN SERVICES DEPARTMENT COMMENTS

New Mexico Human Services Department

Susana Martinez, Governor
Sidonie Squier, Secretary

Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-3103; Fax: (505) 827-3185

October 14, 2011

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX, 75242

Re: New Mexico Response - Medicaid Personal Care Services by Ambercare Home Health
Number A-06-09-00062

Dear Ms. Wheeler:

Enclosed are the New Mexico Human Services Department Medical Assistance Division's comments on the Department of Health and Human Services Office of Inspector General's draft audit report A-06-09-00062 titled "Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health."

Thank you for the opportunity to comment. If you should have any questions, please contact Cathy Sisneros, Chief of the CoLTS Bureau at (505) 827-3178 or by e-mail at Cathy.Sisneros@state.nm.us.

Sincerely,

Julie B Weinberg, Director
Medical Assistance Division
NM Human Services Department

Enclosure

Cc: Sidonie Squier, HSD Secretary
Brent Earnest, HSD Deputy Secretary
Paula McGee, HSD/MAD Healthcare Operations Manager

New Mexico Human Services Department (HSD)
Medical Assistance Division (MAD)

New Mexico Human Services Department Medical Assistance Division Comments on the Department of Health and Human Services Office of Inspector General Draft Audit Report A-06-09-00062 on Medicaid Personal Care Services, Ambercare Home Health

Table of Contents

A. Introduction

In August 2011, the Department of Health and Human Services ("DHHS") Office of Inspector General ("OIG") issued a draft report entitled "Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health" ("Draft Audit") covering claims from October 1, 2006, to September 30, 2008. The Medical Assistance Division ("MAD") of the New Mexico Human Services Department ("HSD") has reviewed the Draft Audit, and collected information from the Coordination of Long Term Services program ("CoLTS") regarding the claims Ambercare submitted. MAD also requested, received, and reviewed documentation from Ambercare offered in support of its response to the Draft Audit, and met with Ambercare officials on September 27, 2011 to discuss this documentation. On October 4, 2011, MAD spoke with OIG staff regarding the specific Ambercare claims alleged to be deficient.

B. Summary of Response

MAD's review of the Draft Audit generally confirms the OIG's findings concerning the specific claims selected for review. But MAD strongly disagrees that these findings support the recommendation of the Draft Audit that the State return $954,013.00* in Federal funds received in response to the Ambercare claims and paid to the provider.

The Draft Audit identifies six categories of "deficiencies" with respect to 100 reviewed claims, selected on a random basis. It concluded that the claims (or portions of claims) affected by these "deficiencies" amounted to $9,412.00.[1]* It then extrapolated this conclusion to the universe of Ambercare's claims for the two-year review period, to arrive at the amount of $954,013.00 in alleged "overpayments" of Federal funds.

With all due respect, we do not believe this conclusion to be justified. Four of the six categories of "deficiencies" involved no demonstrated overpayment of any kind. Rather, the findings were only that particular documents were missing from the reviewed file. But the overall evidence produced by the review clearly demonstrates that the expenditures made were valid, notwithstanding the absence of the missing documents. Moreover, for the most part the missing documentation related not to federal requirements but to state requirements. There is no basis for concluding that the applicable state law requires recovery of payments made to providers even if there was a violation of those state requirements.

For the other two categories, while MAD acknowledges that the findings support a conclusion that there were overpayments of $1,977.67, they do not support extrapolating that conclusion to the universe of all claims submitted during the two-year review period. The findings do not reveal a pattern of misclaiming or any systemic failure on the part of the provider. The findings concerning unsupported attendant service unit claims are too isolated, and the one instance of a claim for services provided to a

[1] The Draft Audit examined only Ambercare's claims for personal care services. Throughout this response, when this response refers to the amount of a claim, it refers only to the amount included on the personal care services line of each claim, and excludes any amounts claimed for other Medicaid services.

*We reported this payment amount to the State agency in error.

recipient while the recipient was a hospital inpatient is clearly an aberration from the provider's normal practices.

Overall, the findings of the Draft Audit reveal a provider that has been extremely compliant with applicable requirements. At most, the few and mostly isolated "deficiencies," in significant part reflecting no more that the inability to document every instance of compliance, warrant the State insisting upon a corrective action plan from the provider to assure its compliance with state requirements, its maintenance of complete records, and its careful review of claims to avoid submitting claims for services not eligible for reimbursement.

C. Background

MAD is the single state agency responsible for administering New Mexico's participation in the Medicaid program. In 1999, the State began providing PCO services to certain Medicaid-eligible individuals with a disability or functional limitation who require assistanc to enable them to live at home, rather than being institutionalized. PCO services are made available under New Mexico's State Medicaid Plan approved by the Centers for Medicare and Medicaid Services ("CMS").

Pursuant to 42 CFR § 440.167, New Mexico has developed PCO eligibility and service criteria. Individuals aged 21 or older who are eligible r full Medicaid coverage may receive PCO services when they require assistance with at least 2 Activities of Daily Living ("ADLs"), as determined by a contracted Third Party Assessor ("TPA"). PCO beneficiaries work with a Medicaid-approved provider to select a caregiver or attendant. Caregivers and attendants may be friends or family members, so long as they have no financial responsibility for the beneficiaries (e.g. spouses). State law provides that the consumer's legal representative must receive approval from MAD to be the paid caregiver. Service delivery models include Consumer Self-Directed or Consumer Delegated models.

Although for most of the time period covered by the Draft Audit New Mexico's Medicaid Fiscal Agent for claims payment processing processed all PCO provider bills under a fee-for-service model, on August 1, 2008, the State implemented the CoLTS Managed Care System that covers all primary, acute, and long-term Medicaid and Medicare services, including PCO services. The CoLTS program operates under CMS-authorized, concurrent 1915(b) and (c) Medicaid waivers. Two managed care organizations ("MCOs")—AMERIGROUP Community Care Inc. and EVERCARE of New Mexico Inc.—have contracts to provide CoLTS services. The State phased-in CoLTS in certain geographic areas over the first year of implementation, and phased in all counties by April 1, 2009.

D. Alleged Ambercare Deficiencies

The OIG's Draft Audit concluded that MAD did not always ensure that Ambercare's claims for Medicaid PCO services complied with applicable Federal and State requirements. The auditors determined that of the 100 sample claims from October 1, 2006, through September 30, 2008, that were examined, 77 (totaling $102,160 were in full compliance, and 23 (totaling $9,412) were not. The auditors further determined that 13 of the 23 non-compliant claims were partially allowable. The Draft Audit identified 25 alleged deficiencies contained in those 23 claims that fall into the following 6 categories:

- Unsupported attendant service units (13 claims)
- Missing documentation demonstrating attendants' completion of annual training (6 claims)
- Missing prior approval for personal care services provided by a legal guardian or attorney-in-fact (3 claims)
- Missing attendants' cardiopulmonary resuscitation ("CPR") certification (1 claim)
- Payment of PCO services for dates when recipient was in hospital (1 claim)
- Missing physician's authorization (1 claim)

As is shown in the following paragraphs, while some of the alleged deficiencies do indicate that claims were paid that should not have been paid, almost half of the alleged deficiencies involved technical or documentation problems that do not support a conclusion that payments were improperly made.[2]

We respond to each of the six categories of "deficiencies" below.

1. Unsupported Attendant Service Units

Draft Audit Finding: The OIG determined that for 13 of the sampled claims Ambercare failed to provide documentation supporting the number of units claimed for attendant services. The total allegedly deficient portion of these 13 claims is $1,586.23.

MAD Response: MAD concurs with the OIG's determination that in certain instances, the amounts claimed by Ambercare exceeded what should have been billed by $1,586.23. For each claim at issue, MAD compared the units documented on the time sheets accompanying Ambercare's claims with CoLTS' records of the units for which Ambercare was paid, and determined that Ambercare claimed and was paid for units exceeding those reflected on Ambercare's submitted time sheets. In several cases, these records demonstrate that Ambercare claimed units exceeding the recipient's approved Plan of Care. MAD notes, however, that the amount of the overpayment is only a minute percentage of the total PCO claims reviewed. The $1,586.23 in excess billings is less than 1.5 percent of the $111,572.35 in PCO claims contained in the 100 cases included in the audit review.

2. Missing Annual Training Documentation

Draft Audit Finding: The OIG auditors found that for 6 of the 100 sampled claims Ambercare lacked documentation showing that attendants had completed 12 hours of training in the calendar year in which they furnished services to Medicaid recipients, as required by section 8.315.4.11A(33) of the New Mexico Administrative Code ("NMAC"). The claims in question total $5,512.23. The Draft Audit would reject these claims in their entirety.

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[2] The Draft Audit also identified two types of deficiencies in Ambercare's claims that did not violate either Federal or State law in effect at the time the claims were made:

- Charging for attendants' meal preparation and housekeeping services when attendants and recipients live in the same home (47 claims)
- Documenting an attendant as simultaneously performing services for 2 recipients living in the same household (2 claims)

MAD Response: Federal law does not require attendants to undergo a specified amount of training in the calendar year in which they furnished service, and therefore there is no justification for withholding federal funds based on a finding that such training was not provided. Even assuming that the State requirement had been violated, State law does not require withholding payment from providers where the requirement is not met.

Enforcement of a State training requirement by withholding Federal funds, when it is otherwise apparent that eligible services were provided to an eligible recipient in amounts authorized by a service plan, is unwarranted. That is particularly illustrated by one of the sample cases, in which the Draft Audit recommends withholding payment for services that were provided during the first two days of the calendar year by an attendant who had completed 12 hours of training in the preceding calendar year and 7 hours of training in the year in which services were furnished, but had not completed an additional 5 hours of training in the year after providing services on January 1 and 2. It stretches credulity to believe that the State would find a violation of its requirements, warranting recovery of otherwise valid payments in this circumstance.

In these six cases, the record documents that eligible services were provided to eligible recipients in an appropriate setting in accordance with a physician-approved plan of care. This satisfies the Federal requirements for federal financial participation ("FFP"), and the failure to meet a State training requirement, even if proved, does not justify withholding that FFP.

3. Missing Prior Approval of Legal Guardian or Attorney-in-Fact Services

Draft Audit Finding: The Draft Audit determined that for 3 of the 100 sampled claims Ambercare did not provide evidence that MAD issued prior approval for personal care services provided by the recipient's legal guardian or attorney-in-fact, as required by section 8.315.4.11A (21) of the NMAC. The 3 allegedly deficient claims total $1,165.94. The Draft Audit would reject these claims in their entirety.

MAD Response: Federal law does not require prior State agency approval for a legal guardian or attorney-in-fact to provide paid personal care services, and therefore there is no justification for withholding Federal funds based on a finding that such approval was not provided. Even if the State requirement had been violated, State law does not require withholding payment from providers where the requirement is not met.

In all 3 of these cases, the record documents that eligible services were provided to eligible recipients in an appropriate setting, in accordance with a physician-approved plan of care. This satisfies the Federal requirements for FFP, and the failure to meet a State requirement of prior approval for legal guardians, even if proved, does not justify withholding that FFP.

4. Missing CPR Certification

Draft Audit Finding: The OIG auditors determined that in 1 out of the 100 sampled claims Ambercare could not provide copies of the attendant's CPR certification as required by section 8.315.4.11A (2)(d) of the NMAC. The amount of the claim in question is $345.15. The Draft Audit would reject this claim in its entirety.

MAD Response: There is no Federal requirement that an attendant be certified for CPR, and therefore no justification for withholding Federal funds based on a finding that such approval was not provided. Even if the State requirement had been violated,, State law does not require withholding payment from providers where the requirement is not met.

Moreover, the absence of such certification from only 1 of the 100 case files reviewed does not support a conclusion that the provider in that one case did not have the required CPR certification. In fact, the existence of the certification in every other sampled record demonstrates that the provider uniformly required that certification to be obtained. The absence of evidence of the certification in one case at best shows only that the certification document was lost or misplaced—not that certification was not secured.

5. Services Paid While Recipient Was in Hospital

Draft Audit Finding: The OIG auditors determined that for 1 of the 100 sampled claims Ambercare was paid for personal care services for dates when the recipient was in a hospital, in violation of 42 C.F.R. § 440.167 and section 8.315.4.13B of the NMAC. The allegedly overpaid portion of the claim in question amounts to $391.44.

MAD Response: MAD concurs with the OIG's determination that in 1 case the record shows that payments were made for services provided on dates when the recipient was in a hospital. We have asked Ambercare to review this case and to advise whether its claim covered services provided to its recipient while the individual was hospitalized. Even if true, this appears to have been an isolated circumstance that is not reflective of a pattern or practice of this provider.

6. Missing Physician Authorization

Draft Audit Finding: The OIG auditors found that for 1 of the 100 sampled claims Ambercare did not have records demonstrating that the recipient had obtained prior physician authorization for the furnished services, as required by 42 C.F.R. § 440.167 and section 8.315.4.16A(1) of the NMAC. The amount of the claim in question is $672.86. The Draft Audit would reject this claim in its entirety.

MAD Response: The absence of a physician authorization form in only 1 of 100 sample cases does not support a conclusion that the services in that 1 case were not provided pursuant to a physician's authorization. The requisite forms were apparently found in the other 99 case records reviewed. The far more reasonable conclusion from these facts is that the evidence of the physician's authorization in the one case was lost or misplaced. The existence of the necessary documentation in the other 99 cases is powerful evidence that the provider's uniform practice was to secure such authorizations prior to rendering the service. In fact, it is difficult to see how the service could be provided in the absence of a physician's authorization, which would normally accompany the development of the service plan for the recipient.

Moreover, Ambercare was able to produce a physician authorization form for the 1 case. But because of the poor quality of the handwriting, it is not possible to decipher the date of that form. Nevertheless, the existence of the form supports the conclusion that the service in this case was pursuant to a

physician's authorization, and corroborates the conclusion that is clearly warranted based on the otherwise uniform showing of the required forms in the other 99 sample cases.

7. Other PCO Matters

Draft Audit Finding: The OIG auditors found that for 47 of the sampled claims Ambercare charged a total of $17,755 in attendants' meal preparation and housekeeping services even though the attendants and recipients lived in the same home. The OIG determined that at the time, such claims did not violate Federal or State law; however, the State has since amended sections 8.315.4.16 and 8.315.3.17 of the NMAC to prohibit such claims.

The Draft Audit also found that for 2 of the sampled claims Ambercare billed the State for attendants' simultaneous performance of services for two recipients who lived in the same household. The OIG determined that such claims did not violate either Federal or State law, although it concluded that paying twice for the same unit of time may not always be reasonable.

MAD Response: MAD concurs that neither claims for meal preparation and housekeeping services provided by an attendant living in the recipient's home, nor paying twice for the same unit of time, violated Federal or State law in effect during the time period covered by the Draft Audit.

E. State Policy Changes and Compliance Measures

As shown above, since 2009, PCO services have been provided in New Mexico entirely through the CoLTS Managed Care System. Two MCOs have been responsible for the delivery of the services and for assuring provider compliance with applicable state and federal requirements. Yet MAD retains ultimate responsibility for this, as well as all other aspects of the State's Medicaid program, and has mounted a range of actions to assure that PCO services are being provided properly and in compliance with law and regulations. The State's continuing efforts in this area have included a series of regulation changes adopted in 2010 and 2011, and implementation in 2010 of a Monthly PCO Billing and Administrative Workgroup to evaluate and spur improvement in program performance. In addition, the State has taken a number of corrective measures that focus on the areas addressed by the Draft Audit findings, all of which have been intended to improve provider performance.

The State's efforts at improved performance are continuing. It has begun planning for an evidence-based program monitoring system that will enhance the quality of PCO services. In addition, it is exploring the implementation of a telephonic and GPS tracking system, like that used in other states, to allow for automatic generation of PCO provider timesheet entries. There is a $2 million cost associated with this enhancement.

The Appendix to this Response describes in greater detail the steps that the State has taken and plans on taking in the near future to assure improved program performance. The State is confident that these steps have contributed and will continue to contribute to the high level of performance and compliance that has characterized its PCO providers, including Ambercare.

F. Response to Proposed Overpayment Recovery

After calculating that 23 claims or portions of claims derived from the sample resulted in overpayments of $9,412.00, the Draft Audit used "statistical software" to extrapolate the total refund due to the Federal Government to be $954,013.00 in FFP for alleged unallowable PCO service claims by Ambercare from October 1, 2006 through September 30, 2008. The State takes strong exception to this conclusion.

As shown above, there is no justification for recovery of any Federal funds, with or without extrapolation, with regard to 11 of the 23 questioned claims, which represent $7,696.18, or over 80% of the $9,412.00 identified as overpayments by the Draft Audit.[3] For these claims, the findings of the Draft Audit do not support a conclusion that payments were improperly made. Rather, they show that only a minute number of files are missing a document that would confirm the satisfaction of a particular requirement. The overwhelming demonstration in the 100 sample case records of compliance with the requirements in question (securing physician authorization for the PCO services, provider CPR and service training, and approval for legal guardian service delivery) negates any conclusion of non-compliance in the few instances where a document was missing from a file.

Further, to the extent the absence of documentation in the case file relates to State requirements, rather than to provisions of the Federal regulations (as in the cases of the CPR and service training or the approval for legal guardian service delivery) it is inappropriate to withhold Federal funding. Nothing in State law requires that funds necessarily be withheld in any instance where a case record fails to document compliance with these State requirements.

As to the portions of the Draft Audit relating to excessive billing, the findings reveal no pattern or practice of non-compliance by Ambercare. To the contrary, of the total of $111,572.35 in PCO claims reviewed in the audit, only $1,586.23 represented amounts claims in excess of the time reflected on the timesheets or that was authorized by the service plan. This is less than 1.5 percent of the total amounts claimed, a level of error considerably lower than the tolerance levels established in various quality control programs in Medicaid and other federal funded programs. *See, e.g.,* 42 C.F.R. § 431.865 (establishing a 3% tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program; 45 C.F.R. §205.42 (1980) (establishing a 4% tolerance limit for payment errors in the Aid to Families with Dependent Children program). In these programs, it is standard federal policy, when overall performance is within the established tolerance limits, to seek recoveries only for specific overpayments actually identified, and not to extrapolate the results of a review to the caseload as a whole. That policy should be applied in this case, where the level of erroneous payments is as low as it is.

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[3] The Draft Audit concluded that 2 of the sampled claims each had 2 types of "deficiencies": 1 claim had missing evidence of annual training and unsupported units of payment, and another had unsupported units of payment and missing evidence of prior State approval of PCO services provided by a legal guardian or attorney-in-fact. In both instances, the Draft Audit used the larger of the "deficiency" amounts (entirety of the claim for missing annual training evidence and prior approval of legal guardian or attorney-in-fact services, respectively) in calculating the total Federal share of the 23 "deficient" claims.

Similarly, the existence of one instance of a provider claim for a recipient during the time of a hospital stay (even assuming that Ambercare is not able to provide a satisfactory explanation for this aberration) is an insufficient basis on which to predicate an extrapolation to the caseload as a whole. If the amount of the overpayment in this case ($391.44) is added to those in the 13 excess payment cases, the total overpayments would still be less than 2 percent of all reviewed payments, substantially below the tolerance levels that have been utilized in federally supported public assistance programs.[4]

It should also be mentioned that extrapolation of the results to the caseload as a whole to recover a substantial amount from the State is inappropriate given the continuing efforts of the State (detailed in the Appendix) to assure high quality and compliant performance by PCO providers, even after the conversion to a managed care delivery system.

G. Conclusion

The results of the OIG investigation, reflected in the Draft Audit, are encouraging to MAD, for they demonstrate an extremely high level of compliance by Ambercare. While there is always room for improvement and the State intends to continue its long standing efforts to enhance performance of its PCO providers, the results of the Federal review should provide comfort to Federal officials that Federal funds are being properly spent in the case of Ambercare's PCO services.

Based on the Draft Audit results, the State is prepared to repay $1,413.94,[5] the federal share associated with the 13 instances of overbilling and 1 instance of billing for a hospitalized patient.

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[4] The total overpayments would be $1,977.67, which is 1.77 percent of the $111,572.35 in total claims reviewed.

[5] This amount was calculated by applying a composite FMAP rate of 71.485 percent (the average of the FMAP rates for Federal Fiscal Years 2007 and 2008) to the sample case overpayment of $1,977.67.

Appendix: State Policy Changes and Compliance Measures

1. Overall PCO Improvements

(a) Regulation Changes

In the last year, the state has revised and improved the PCO regulations three times to enhance the State's ability to ensure that the claims submitted by PCO providers comply with Federal and State regulations.

September 15, 2010 PCO Regulation Changes:

- Added language to the CoLTS managed care regulations clarifying the respective roles and responsibilities of MCOs and TPAs;
- Added language requiring MCOs to identify Natural Supports; and
- Added language requiring MCOs to assess services provided to PCO consumers who share a home.

December 30, 2010 PCO Regulation Changes:

- Added language throughout the PCO regulations clarifying that an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), mental health facility, correctional facility or other institutional setting (except for recipients of community transition goods and services) is not eligible for PCO services;
- Added language clarifying that duplicative PCO services are not allowed for individuals receiving the same or similar services by other sources, including natural supports;
- Added cognitive assistance as a service within each ADL and IADL service rather than a stand-alone service;
- Required a legal representative for self-directed individuals who cannot make their own choices or communicate their responses;
- Restructured consumer delegated and directed regulations to avoid repetition and to describe adequately the roles and responsibilities of PCO agencies, caregivers, and beneficiaries;
- Replaced the MAD 075 Medical Assessment Form with the Income Support Division (ISD) 379 Medical Assessment Form, which can be completed using form fields for entry;
- Clarified which PCO services are or are not covered by Medicaid;
- Reduced the hours in which temporary authorization is given, and made this requirement applicable to all new PCO recipients; and
- Included in the regulation MAD 055, the PCO Service Guide, which helps standardize and ensure the accuracy of the calculation of time in which PCO services are furnished. For each PCO recipient function level, the Guide provides a narrative or worksheet establishing standard service time ranges.

September 15, 2011 PCO Regulation Changes:

- Revised the MAD 055 (PCO Service Guide) to combine the pre-existing 10 PCO services into 6 service categories, and to determine appropriate service time ranges for each service:
    1. Hygiene and Grooming—Bathing, dressing, grooming and doctor prescribed skin care;
    2. Bowel and Bladder;
    3. Preparing Meals;
    4. Eating;

5. Household and Support Service—Cleaning, laundry, shopping and minor up-keep for medical equipment; and
6. Supportive Mobility Assistance—Special help transferring from one place to another, walking, and changing positions, provided that such assistance is not part of another PCO service.

Each service includes time spent on "Mobility Assistance" and spoken reminders (called "Prompting and Cueing");

- Prohibited prior authorizations (PA) that are retroactive or extend beyond the level of care ("LOC") authorization period;
- Permitted an MCO to authorize time outside of the time set forth in the MAD 055 for furnishing services to a beneficiary based on his or her verified medical and clinical need(s);
- Required MCOs to discuss with the consumer the results of the service assessment, function level for each PCO task on the MAD 055, and the applicable service time range during the in-home service assessment;
- Required MCOs to make a good faith effort to conduct a pre-hearing conference for beneficiaries who request a State fair hearing. During the pre-hearing conference, the MCO must explain how it applied the PCO regulations, and examine whether additional service time is necessary based on a consumer's verified medical and clinical need(s);
- Clarified that under section 8.352.2 of the NMAC, a PCO recipient who disagrees with the authorized number of hours may utilize the CoLTS MCO grievance and appeal process and the State's fair hearing process consecutively or concurrently; and
- Clarified that the beneficiary, not the provider, is responsible for repaying the cost of continuing benefits pending a fair hearing decision.

(b) PCO Billing and Administrative Workgroup

In 2010, in addition to amending the PCO regulations, MAD implemented a new Monthly PCO Billing and Administrative Workgroup to evaluate PCO provider and CoLTS MCO billing and administrative issues, and to improve the program's performance. The Workgroup was made up of several PCO providers, MCO staff, and representatives from several State Bureaus (CoLTS, Long Term Care Services and Support (LTSSB), Quality Assurance, Contract Administration and Program Information).

The Workgroup identifies systemic problems in the PCO program, root causes for such problems, and possible solutions. In particular, the Workgroup has been tasked with improving the following areas of the PCO program:

- Eligibility;
- MCO Assessments/Authorizations/Hours;
- TPA/Level of Care;
- Service Coordination;
- Transfers from one agency to another;
- Provider Education;
- Billing; and
- Fraud and Program Integrity.

The Workgroup has developed a PCO survey and used the findings from the survey to further refine areas of needed improvement. Many of the regulation changes identified above originated from this

Workgroup to correct error-prone areas. The committee members have also developed work and process flows to help clarify PCO roles and responsibilities, and identify opportunities for program improvement.

The Workgroup is chaired by the CoLTS Bureau Chief, in collaboration with PCO providers and MCOs. The PCO Service manager updates the Workgroup's work plan to ensure that it is accountable for, and successfully addresses the areas of the PCO program listed above.

(c) Continuous Quality Improvement (CQI) Model for PCO

MAD recognizes that an evidence-based approach to program monitoring is one of the best ways to ensure that PCO services are administered in the manner specified in the Federal and State regulations, and safeguard participants' health and welfare. MAD will design and adopt an evidence-based approach to PCO quality modeled after CMS's CQI model for Home and Community Based Services (HCBS) waivers. Planning for this initiative will begin in October 2011, and a reporting mechanism will be in place by January 2012.

MAD's CQI model will impose requirements similar to the statutory assurances states make to CMS as a condition of approval for a HCBS waiver through assurances and sub-assurances structured in a manner similar to the following:

Example #1—Modeling PCO CQI after HCBS Waivers	
1. Level of Care	Persons enrolled in PCO have needs consistent with an institutional level of care.
2. Service Plan	Participants have a service plan that is appropriate to their needs and preferences, and receive the services or supports specified in the service plan.
3. Provider Qualifications	PCO providers are qualified to deliver services or supports.
4. Health and Welfare	Participants' health and welfare are safeguarded, and PCO Attendants are trained, certified and qualified to provide PCO services.
5. Financial Accountability	Claims for PCO services are paid according to State and CoLTS MCO payment methodologies specified in the regulations and MCO handbooks.
6. Administrative Authority	MAD is actively involved in overseeing PCO services and ultimately responsible for all facets of such services.

Example # 2—Sub-Assurances	
1. Level of Care	The levels of care of enrolled participants are reevaluated at least annually
2. Service Plan: Individual Plan of Care (IPoC)	• Service plans and IPoCs are updated or revised at least annually and upon participant need. • Services are delivered in accordance with the IPoC, including the type, scope, amount, and frequency specified in the service plan. • Participants are afforded choice between the delegated and self-directed services model, and providers.
3. Provider Qualifications	The state and MCO verify that providers initially and continually meet required licensure and/or certification standards, and adhere to other state standards before waiver services are furnished.

4. Attendant Qualifications	The state and MCO verifies that attendants initially and continually meet required training and certification standards (including CPR and criminal history screening), and adhere to other state standards before PCO services are administered.

Similar to the HCBS CQI model, MAD will use "Discovery" methodology in the monitoring process to uncover deviations from program design. Discovery will allow Program managers to know when program processes are not being followed, and when the assurances and sub-assurances are not being met. MAD will establish performance measures that (1) are measurable and can be included as a metric, (2) have facial validity, (3) are based on a correct unit of analysis, and (4) are representative. MAD will further identify (1) the data source(s) for each performance measure; (2) a method for assuring that the data will be representative; (3) information on the party or parties responsible for collecting, reviewing, and using the data to manage the program; and (4) the frequency with which summary (i.e., aggregated) reports will be generated and reviewed.

When the State identifies instances in which the PCO program is not operating as intended and does not comply with State and Federal regulations, the State will initiate remediation actions to address and resolve all uncovered, individual problems. The PCO Billing and Administrative Workgroup will review and advise on the remediation process.

2. Corrective Measures Relating to Ambercare Deficiencies

The State has taken several corrective measures that address the deficiencies identified in the Draft Audit, and provide assurance that claims submitted by Ambercare and other PCO service providers comply with Federal and State law.

(a) Supported Units of Payment

Following the audit period covered by the Draft Audit, PCO services managed through the CoLTS managed care contract have significantly changed the way that PCO services are billed and paid.

MCOs now require each PCO agency to obtain MCO authorization for PCO services and timesheets before a claim will be paid. Each MCO has claim processes in place that include methods for assuring that no unsupported claims are paid, including data mining to review units claimed, authorized units, billed claims, and paid claims. In accordance with the State CoLTS contract, each MCO must investigate pursuant to internal compliance procedures and report all instances of fraud, waste, or abuse within 5 business days of detecting suspicious activity to MAD's Quality Assurance Bureau (QAB).

The MCOs investigative unit must employ a consistent investigative strategy that includes logical investigative plans with defined and appropriate investigative measures. In conducting its investigation, the MCO may contact the complainant to verify the allegations and request PCO records from the provider. The MCO must review and research the provider's contract and claims exposure, and any public records pertinent to the allegations. The MCO's report to MAD must identify the PCO provider at issue by name, address, and MCO and National Provider Identification (NPI) numbers. In addition, the notification provides information on the affected beneficiar(y/ies), date, source and nature of

complaint, approximate dollars paid, and a description of the allegations and preliminary findings. The MCO's report constitutes a "notification of complaint."

If QAB refers the allegations to the Office of the Attorney General (AG), the MCO investigative unit assists the AG's office in a supportive role. If QAB does not refer the allegations to the AG's office, the investigative unit may pursue recoupment.

Since 2008, to ensure compliance with Federal and State PCO requirements, the State (ALTSD or MAD's current Quality Assurance program) has conducted site reviews of selected PCO agencies. During these site reviews, the State has compared PCO providers' timesheets against the approved plans of care and MCO authorizations. When deficiencies are identified, the State issues corrective action plans.

In addition, the revisions the State made to PCO regulations in September 2010 and December 2010 stressed the importance of timesheet accuracy. The technical assistance documents provided at PCO trainings, and posted on the ALTSD and MAD websites include a section on "Ensuring Timesheet Accuracy." The State holds quarterly trainings for providers on PCO requirements including those relating to timesheets, and has scheduled a webinar for October 2011 on the revised regulations that went into effect in September 2011.

(b) Annual Training

In September and December 2010, the State revised the PCO requirements to stress the importance of, and adopt measures to facilitate, compliance with the training requirements.

First, the State provides staff training materials and technical assistance electronically to PCO agencies. Guidance on the training requirement, documentation required to demonstrate compliance with the training regulations, and the technical assistance documents provided at trainings are posted to the ALTSD website. The State is working to move these materials to MAD's website. MAD also sends updates on PCO to the Executive Director of the New Mexico Association for Home and Hospice Care, who then regularly sends the updates to PCO agencies through regular email blasts.

Next, both of CoLTS MCOs—Evercare and Amerigroup— provide PCO agencies with continuing education regarding the State regulatory requirements and responsibilities. Evercare provides such education both quarterly and monthly, and documents attendance at such events. The MCOs also stipulate in their contractual agreements that PCO agencies are required to abide by all State and Federal rules of regulations, including the 12 hours of annual training.

- Evercare's Compliance team conducts year-round desk audits of PCO agencies that pull the files of a random sample of agencies over a 9 to 12 month time period. If the Compliance team provides Quality of Care, or fraud, waste, and abuse reports, the sample size and timeframe reviewed may be expanded. Following the audit, the PCO agency receives either an Opportunity Plan for Improvement or a Corrective Action Plan. Non-compliance with the latter risks contractual termination of the PCO agency's contract with Evercare.
- Amerigroup's Quality Management Department (QMD) regularly reviews PCO documentation to investigate beneficiary complaints, critical incidents, and other quality improvement initiatives. If a review indicates that PCO requirements have not been met, Amerigroup's QMD will contact the PCO agency to obtain policies and procedures for personal care attendant qualifications,

training records, and corrective action plans explaining what steps the attendant can take to comply with PCO requirements. If an agency's failure to comply with PCO requirements is egregious and/or the agency does not comply with the request for a corrective action plan, Amerigroup initiates sanctions ranging from a moratorium on new authorizations and transfers, to termination of the PCO agency's contract.

(c) Prior Approval of Legal Guardianship or Attorney-in-Fact Services

Beginning in 2009, the training required of new PCO providers took care to emphasize the importance and the process of approving a legal representative to be a beneficiary's paid attendant. Effective December 2010, MAD's revised PCO regulations clarified the difference between a personal representative and a legal representative, while continuing to emphasize the need for the State's prior approval of appointment of the legal representative. Technical assistance documents provided at the trainings and posted on the ALTSD and MAD websites further reinforce this regulatory requirement, and provides guidance on the information needed to obtain approval.

The MCO Service Coordinators assist in assuring compliance with the prior approval for paid legal representatives requirement. If the Service Coordinator discovers a legal representative acting in the role of the paid attendant without obtaining prior state approval, he/she will alert the PCO agency. In addition, if a beneficiary communicates to the Service Coordinator either at the time of assessment or by calling the Customer Service Line that he or she wishes to employ their legal representative as his or her paid attendant, the Service Coordinator contacts the PCO agency, on the beneficiary's behalf, to facilitate the process. The request is documented in the beneficiary's file.

(d) CPR Certification

The MCOs stipulate in their contractual agreements that PCO agencies are required to abide by all State and Federal regulations, including requiring all attendants to have current and valid CPR certifications. As detailed above in the discussion of corrective strategies relating to the annual training requirement, MCO has established strategies for assuring compliance with the CPR certification requirement.

Since the transition to Managed Care, PCO providers have been required to develop an IPoC service plan in accordance with the services authorized by the consumer's MCO. Agencies must keep on file the MCO's authorization for services.

(e) Services Claimed While Recipient Was in Hospital

Practically speaking, because the majority of PCO beneficiaries are dually eligible for Medicaid and Medicare, CoLTS is not the primary payer and hospitals are under no obligation to report inpatient admissions. Nonetheless, MCOS must put in place claim processes that assure that providers are not paid for services purportedly furnished to beneficiaries while they are in the hospital. If the MCO learns that a person for whom PCO services are authorized has been admitted to a hospital, the MCO may terminate the authorization for the PCO services. When PCO providers are reimbursed for services claimed for dates when the beneficiaries are in fact in a hospital, and the claim has already been paid, a MCO's investigative unit is required to independently investigate the claim. If the investigative unit determines that the MCO was billed for services that were not furnished, the investigative unit must

forward its findings to MAD's QAB. The MCO may seek recoupment, and if necessary, assist the AG in its investigation.

(f) Physician Authorization

As explained above, the State's managed care system requires PCO providers to develop an IPoC service plan consistent with the services authorized by the PCO, and to keep on file the MCO's authorization.

Each MCO tracks LOC-approved time spans authorized by the TPA and sends the authorizations to the PCO agencies on a tracking sheet. Additionally, MCOs track the LOC expiration date so that beneficiaries can be notified at least 120 days prior to the expiration date so the beneficiary can begin collecting information needed to renew the LOC. If the renewal documentation is not submitted in the next 30 days, MCOs send a second letter to the beneficiary again requesting the documentation. This letter instructs the beneficiary to take two attached forms to his or her physician for completion, and to return the forms to the MCO via e-mail or fax. Each MCO also works with the state to identify any beneficiaries for whom the LOC period is unclear to avoid gaps in the LOC process. MAD and the MCOs are currently revising this notification process to ensure compliance with Federal regulations.

3. Other PCO Matters

When it revised the PCO regulations in December 2010, MAD introduced a PCO Service Guide to record observations and responses to an individual's functional level and independence to perform ADLs and IADLs. The guide provides an impairment rating system for identifying PCO services and service time ranges. The guide requires a service coordinator to identify and record whether the beneficiary shares a household with other PCO recipients and name the other PCO recipients. The new PCO rules strengthened the regulations to clarify that duplicative PCO services are not allowed for individuals receiving the same or similar services by other sources, including natural supports.

Also, each MCO monitors shared households to prevent duplication of services through the following strategies:

- Staff report alleged shared household fraud, waste, or abuse to the compliance unit via the MCO internal reporting process. Such an allegation opens an investigation that reviews the allegation and recommends to the PCO agency that particular action be taken, such as terminating the attendant or discharging the recipient from the PCO program.
- Service Coordinators are trained to consider shared households when completing the Functional Assessment Guide MAD 055. If a PCO recipient resides in the same household as another recipient, and the two recipients receive services through different MCOs, the recipients' Service Coordinators ascertain which tasks each recipient receives, and how many and attendant hours are provided. The Service Coordinators then determine the hours needed for each recipient based on his or her individual needs. The MCOs work collaboratively with the PCO agencies and with each other to identify scenarios in which one caregiver may be working for multiple agencies and clients and attempting to be paid for overlapping hours (e.g. receiving 80 hours pay for two PCO beneficiaries in a shared household with overlapping services such as meal prep and housekeeping).

4. Planned Upgrade in Service Reporting

The State hopes to put in place a telephonic and GPS tracking system already implemented by several other states, including New York and Washington, that would enable time sheets to be automatically generated. Under this system, each day, either an attendant would call in whenever he or she begins and finishes providing PCO services to each beneficiary, or the attendant's location would be tracked using a GPS system to determine when the attendant was at a site to furnish services to a beneficiary. The system would then automatically fill in the attendant's time sheets and calculate the hours the PCO provider would claim. This system should substantially reduce the potential for human errors in entering time sheets, while minimizing the time required to complete time sheets. The State has estimated that this system would cost approximately $2 million.