DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 14, 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 Heritage Home Healthcare (A-06-09-00063)

Attached, for your information, is an advance copy of our final report on New Mexico Medicaid personal care services provided by Heritage Home Healthcare. 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, Region VI, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00063.

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

May 15, 2012

Report Number: A-06-09-00063

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

Dear Ms. Weinberg:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare*. 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-06-09-00063 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 HERITAGE HOME HEALTHCARE

Daniel R. Levinson
Inspector General

May 2012
A-06-09-00063

Office of Inspector General

http://oig.hhs.gov

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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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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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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 services plan. In addition, New Mexico law requires a supervisor from the personal care services provider agency to visit each recipient or his or 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, Heritage Home Healthcare (Heritage), a personal care services provider in Albuquerque, New Mexico, received $22,454,952 ($16,058,247 Federal share).

OBJECTIVE

Our objective was to determine whether the State agency ensured that Heritage'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 Heritage's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 claims in our sample, 64 (totaling $3,837) complied with requirements, but 36 (totaling $2,243) did not. Those 36

claims contained a total of 41 deficiencies: 35 deficiencies on insufficient attendant qualifications and 6 deficiencies on other issues. As a result, Heritage improperly claimed $2,243 for the 36 claims.

Based on our sample results, we estimated that Heritage improperly claimed at least $4,483,492 (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 $4,483,492 paid to Heritage for unallowable personal care services and

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

HERITAGE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Heritage disagreed with almost all of our findings. Heritage did not dispute our finding that 1 hour was mistakenly billed because the client was in the hospital. Heritage disagreed with our remaining findings. Heritage's comments are included in their entirety as Appendix D.

Along with its comments, Heritage provided documentation that it did not provide during our review. After reviewing the documentation, we reevaluated some claims and determined that 15 complied with Federal and State regulations. We revised the findings and recommendations accordingly.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, the State agency disagreed with our recommended refund amount paid to Heritage for improper claims submitted for the audit period. The State agency said that four of the five categories of deficiencies (i.e., training documentation, cardiopulmonary resuscitation and first aid certification, tuberculosis testing, and prior approval of legal guardian) 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 these four categories are not Federal requirements; they are State requirements, which do not require recovery of payments. The State agency added that the remaining category (i.e., unsupported attendant service units) supports the conclusion that an overpayment was made but that the deficiency does not support extrapolating to the population because (1) the finding does not reveal a pattern of noncompliance and (2) the overpayment was within the tolerance limits established by certain Federal programs.

The State agency also said that the Federal Government's requirement to recoup nearly 20 percent of the Federal funds Heritage received during the audit period is unreasonable, particularly because we reviewed only 100 claims, or less than 0.03 percent, of the 363,903 claims Heritage submitted during the audit period.

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 four 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.

In addition, 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.

Finally, if we had used a larger sample size, as State agency comments imply we should have, the amount we recommended for recovery from Heritage probably would have been higher. A larger sample size usually yields estimates with better precision without affecting the estimate of the mean. Better precision would typically result in a larger lower limit for the confidence interval of the estimate. Therefore, had we used a sample size larger than 100, the estimated lower limit for the 90-percent confidence interval probably would have been a higher amount. Also, guidance provided in the CMS *Program Integrity Manual* (subsection 3.10.4.3, "Determining Sample Size") states: "A challenge to the validity of the sample that is sometimes made is that the particular size of the sample is too small to yield meaningful results. Such a challenge is without merit …."

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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 personal care services 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 those assessments and the 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 (TB), 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 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 (if warranted) 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, Heritage Home Healthcare (Heritage), a personal care services provider in Albuquerque, New Mexico, received $22,454,952 ($16,058,247 Federal share).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

This audit covered the $22,454,952 the State agency paid to Heritage for 363,903 claim lines (hereafter referred to as "claims") for the period 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 Heritage's procedures for maintaining documentation related to attendants and recipients.

We conducted our fieldwork at the State agency office in Santa Fe, New Mexico, and at the Heritage office and the third-party assessor's office, which are located in Albuquerque, 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 Heritage to review based on payments for personal care services claims it received (totaling $22,454,952) for the audit period;
- selected a random sample of 100 Heritage claims (Appendix A);
- met with Heritage officials to gain an understanding of Heritage's policies and procedures and of documentation in Heritage's recipient and attendant personnel files;
- obtained recipient documentation from the third-party assessor and Heritage for each sampled item;
- identified the attendant(s) included in each sampled item and obtained documentation Heritage maintained in the corresponding 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 sample 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 Heritage;

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

- calculated the value of the unallowable reimbursement Heritage received for the sampled items; and

- estimated the unallowable Federal Medicaid reimbursement paid for the 363,903 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 Heritage's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 sampled items, 64 claims (totaling $3,837) complied with requirements, but 36 (totaling $2,243) did not. Those 36 claims contained a total of 41 deficiencies: 35 deficiencies on insufficient attendant qualifications and 6 deficiencies on other issues. As a result, Heritage improperly claimed $2,243 for the 36 sampled items.

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

Based on our sample results, we estimated that Heritage improperly claimed at least $4,483,492 (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 the attendants' files copies of documentation that all training has been completed. For 28 of the 100 sampled items, Heritage did not provide evidence that the attendants had completed 12 hours of annual training for the year of the dates of service.

Cardiopulmonary Resuscitation and First Aid Certifications

NMAC section 8.315.4.11A(2)(d) requires provider agencies to maintain copies of all CPR and first aid certifications in the attendants' files and to ensure that these certifications are current.[1] For 6 of the 100 sampled items, Heritage did not provide evidence that the attendant was certified in CPR and/or first aid on the dates of service.

Tuberculosis Testing

NMAC section 8.315.4.11A(37) requires provider agencies to ensure that their attendants obtain a TB skin test or chest x-ray upon initial employment and to document the results of TB tests and x-rays in attendant files. NMAC specifies that an attendant who tests positive for TB cannot begin providing services until he or she receives appropriate treatment. For 1 of the 100 sampled items, Heritage did not provide evidence that the attendant had received a TB skin test or chest x-ray or that the attendant had tested negative for TB or had been appropriately treated before the dates of service.

OTHER DEFICIENCIES

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

NMAC section 8.315.4.11 A(21) requires prior State agency approval for any personal care services provided by the recipient's legal guardian or attorney-in-fact. For 5 of the 100 sampled items, Heritage did not provide evidence that the State agency had issued prior approval.

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 1 of the 100 sampled items, Heritage did not have evidence to support the number of units it claimed for attendant services.

EFFECT OF DEFICIENCIES

Based on our sample, we estimated that Heritage improperly claimed at least $4,483,492 (Federal share) for personal care services.

RECOMMENDATIONS

We recommend that the State agency:

[1] The entities that provided the training determined how long the certificates were valid, typically 2 to 3 years from the date the attendants passed the courses.

- refund to the Federal Government the $4,483,492 paid to Heritage for unallowable personal care services and

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

HERITAGE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Heritage disagreed with most of our findings. Heritage's comments, which we summarize below, are included in their entirety as Appendix D.

Along with its comments, Heritage provided documentation that it did not provide during our review. After reviewing the documentation, we reevaluated some claims and determined that 15 complied with Federal and State regulations.[2] We revised the findings and recommendations accordingly.

Conditions of Payment Versus Conditions of Participation

Heritage Comments

Heritage stated that recoupment is not an appropriate remedy for the deficiencies noted in the report because compliance with personal care option (PCO)[3] services regulations is not a condition of payment; it is a condition of participation. Heritage stated that in the context of the False Claims Act, courts have frequently held that a provider is not liable for repayment or recoupment for failures to comply with governmental regulations "unless, as a result of such acts, the provider knowingly asked the government to pay amounts it did not owe." Heritage added that PCO regulations support recoupment of payments only when there is inappropriate billing of services in accordance with NMAC section 8.315.4.11(A)(14) and that, with one very limited exception, the basis for recoupment is not triggered by the various alleged deficiencies outlined in the draft report.

Office of Inspector General Response

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 attendant. To be a qualified attendant in New Mexico, the attendant must meet the NMAC requirements related to the attendant qualifications discussed above. Therefore, the NMAC attendant qualification requirements are conditions of payment because an attendant who is not qualified cannot provide valid personal care services as defined by Federal statute and regulation. We based the other

[2] We based our original findings and our reevaluations on NMAC section 8.315.4, which was implemented on July 1, 2004, and was in effect during our audit period. The regulations have since been revised.

[3] In its comments on our report, Heritage used the terms "PCO" and "personal care option," which are synonymous with the term "personal care services" that we used throughout the report.

deficiencies we identified 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.

Substantial Compliance

Heritage Comments

Heritage stated that it was in substantial compliance with NMAC regulations. Heritage said that the Tenth Circuit Court of Appeals had observed that perfect compliance was not a necessary condition to receive Medicare reimbursement and that it believes the same is true for Medicaid reimbursement. Heritage stated that at no time was the health or safety of any client at risk, nor was care provided in a manner that would cause harm to its clients. Heritage added that we failed to apply a reasonableness standard to compliance with the regulations. Specifically, we based our recommendation on 6 of the 38 requirements in the regulations and failed to acknowledge that Heritage had a 90-percent or better compliance rate for nearly all of those 6 categories. Heritage stated that many of the technical deficiencies that were noted relate to requirements that the New Mexico Human Services Department does not impose on personal care attendants under the consumer-directed care model.[4]

Office of Inspector General Response

We evaluated each sample item for compliance with Federal and State regulations. In addition, we based the attendant qualification deficiencies cited in the report on significant service-related requirements. Taken as a whole, these deficiencies are sufficiently numerous and widespread to be considered more than just technical deficiencies; they could affect quality of care. In addition, all 363,903 claims in Heritage's population were for services related to the consumer-delegated model.

Sampling Methodology

Heritage Comments

Heritage stated that our recommendation for recoupment using an extrapolation ratio of 1 to 3,639 (i.e., our sample of 100 out of 363,903 claim lines) was unprecedented in New Mexico and added that it disputed the statistical validity of both our sample size and extrapolation.

Heritage stated that our sample was not statistically valid because we did not rely on a valid statistical procedure. Heritage said that we appear to have chosen a sample of 100 claims, not based on any statistical analysis of the variance, or heteroskedasticity, of the pool (which is the ordinary procedure for statistical sampling), but on the assumption that this would be sufficient and, perhaps, on the simplicity of using a round number. Heritage added that this methodology

[4] Office of Inspector General note: New Mexico personal care services were provided under two models: consumer-delegated and consumer-directed. The consumer-delegated model (NMAC section 8.315.4.11) placed the responsibility for ensuring attendant qualifications (e.g., annual training) on the provider. The consumer-directed model (NMAC section 8.315.4.10) did not place responsibility for ensuring attendant qualifications (i.e., annual training, CPR and first aid certifications, and TB testing) on the provider.

is contrary to accepted statistical methodology, as well as the guidance provided in the CMS *Medicare Program Integrity Manual*.

Heritage also stated that our sample rate of 0.0275 was insufficient to support our conclusions because the number of claims (363,903), attendants (720), and clients (848) during the sample period would be expected to exhibit variance. Heritage stated that the results demonstrate the intrinsic variability of the sample and the need for additional sampling. Heritage added that no court appears to have ever confronted such unreliable statistical analysis in a similar setting and that courts have dealt only with actual statistical sampling that resulted in sampling rates typically between 5 and 10 percent and only as low as 0.07 percent. Heritage stated that traditional sampling estimates for this type of data require a sample rate of at least 2 percent, adding that the high variability and extremely small sample size of this sample yielded unreliable results when extrapolated to the universe of claims.

Heritage concluded by stating that it had conducted its own 100-percent review of the personnel files of its 702 homemakers, personal care attendants, and home health aides and found that its review supports the conclusion that our statistical analysis is invalid.

Office of Inspector General Response

Courts have long upheld the validity of using sampling and extrapolation in audits of Federal health programs.[5] In particular, one court found that "[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."[6] Courts have not determined how large a percentage of the entire universe must be sampled to be held valid;[7] however, the type of sample used here—a simple random sample—is recognized as valid for extrapolation purposes.[8] Further, such statistical sampling and methodology may be used in cases seeking recovery against States, individual providers, and private institutions.[9]

[5] See, e.g., *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409-410 (N.D. Ga. 1977) (ruling that sampling and extrapolation are valid audit techniques for programs under Title IV of the Social Security 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 for calculating Medicaid overpayments claimed against an individual physician).

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

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

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

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

We did rely on a statistically valid sample.[10] 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." We select our samples according to principles of probability (every sampling unit has a known, nonzero chance of selection). We use the difference estimator (an unbiased estimator) for monetary recovery and recommend recovery at the lower limit of the 90-percent, two-sided confidence interval. We use the sampling error in the computation of the 90-percent, two-sided confidence interval. In addition, the term "heteroskedasticity" is ordinarily used in time series or regression analysis; because we used a simple random sample and the difference estimator to arrive at the estimates in the draft report, this term is not relevant.

If we had used a larger sample size, as Heritage's comments imply we should have, the amount we recommended for recovery from Heritage probably would have been higher. A larger sample size usually yields estimates with better precision without affecting the estimate of the mean. Better precision would typically result in a larger lower limit for the confidence interval of the estimate. Therefore, had we used a sample size larger than 100, the estimated lower limit for the 90-percent confidence interval probably would have been a higher amount. Also, guidance provided in the CMS *Program Integrity Manual* (subsection 3.10.4.3, "Determining Sample Size") states: "A challenge to the validity of the sample that is sometimes made is that the particular size of the sample is too small to yield meaningful results. Such a challenge is without merit …."

The sampling frame for our sample was 363,903 PCO services related to direct attendant care (procedure code T1019) for which Medicaid paid Heritage during the period October 1, 2006, through September 30, 2008. From that list, we selected 100 services for our sample. Heritage's PCO services were not compared or extrapolated to Heritage PCO attendants or Heritage PCO clients.

For Heritage to have conducted a 100-percent review of the population from which our sample was drawn, Heritage would have had to review all PCO direct attendant care services provided by the 702 homemakers, personal care attendants, and home health aides and reimbursed by Medicaid during the period October 1, 2006, through September 30, 2008. Even if Heritage had reviewed support for all 363,903 claims in the sampling frame, the result of that review would not likely have been as accurate as the results of a sample review. The decision in New York State Department of Social Services, DAB No. 1358 (1992), stated: "… sampling (and extrapolation from a sample) done in accordance with scientifically 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."

[10] See Puerto Rico Department of Health, DAB (Departmental Appeals Board) No. 2385 (2011) (DAB upholding disallowance of claims based on statistical sampling and statistical methodology that mirror those used in this audit).

Units Claimed

Heritage Comments

Heritage stated that it did not dispute our finding in the "Unsupported Units Claimed" section. Heritage explained that the attendant wrote on the timecard that the client was in the hospital for the claimed hour and that the billing was a clerical mistake, not a willful or fraudulent act. Heritage said that it will reimburse the State agency for the hour.

Heritage added that it will voluntarily review all timecards from the period August 1, 2008, through August 31, 2010, and repay any identified amounts received for time during which clients were institutionalized.

Office of Inspector General Response

We did not imply that Heritage committed a willful or fraudulent act by billing 1 hour of service for a client who was institutionalized. We questioned this claim because the time charged overlapped with a hospitalization as indicated on the timesheet. We support Heritage's efforts to address this issue.

Criminal Background Checks

Heritage Comments

Heritage stated that it had located a letter from the State for the sample item in the "Criminal Background Checks" section of the draft report and that the letter cleared the attendant to work.

Office of Inspector General Response

The documentation that Heritage provided addressed this deficiency. We removed this section from the report.

Tuberculosis Testing

Heritage Comments

Heritage stated that it had provided us with documentation supporting negative TB test results for some of the sample items in the "Tuberculosis Testing" section of the report but could not provide the original negative TB test results for other sample items. Heritage also stated that some of its attendants were not required to have a TB test because they were hired before the effective date of the regulation in 2004 and that the requirements in the regulations were not retroactive. However, Heritage provided TB questionnaires that it said were sufficient evidence based on its practice of administering the questionnaires after attendants had received a negative TB test result. Heritage stated that it has since sought and obtained negative TB test results for the attendants identified in the audit who Heritage still employed.

Office of Inspector General Response

The negative TB test results that Heritage provided addressed most of the deficiencies identified in the report. In addition, we confirmed with the State agency that attendants hired before the effective date of the regulation in 2004 and without a TB test should not be included in our report. We revised the report accordingly. However, for the remaining deficiencies, we did not accept Heritage's assertion that TB questionnaires were sufficient evidence that attendants had received negative TB test results. In accordance with NMAC section 8.315.4.11A(37), we counted a sample item as deficient if Heritage could not provide medical documentation that the attendant tested negative for TB from a TB skin test or chest x-ray.

Cardiopulmonary Resuscitation and First Aid Certifications

Heritage Comments

Heritage stated that it had provided documentation for some of the sample items listed in the "Cardiopulmonary Resuscitation and First Aid Certifications" section. Heritage said that its 92-percent compliance rate demonstrates substantial compliance with the regulations and added that attendant certifications that had lapsed during the date of service had been renewed.

Heritage stated that it has voluntarily taken steps to improve its compliance rate for these certifications by ensuring that attendants will not be scheduled for work without proof of a current CPR and first aid certification.

Office of Inspector General Response

We accepted the CPR and first aid certifications that Heritage provided for some of the sample items and reduced the deficiencies noted in the report accordingly. Although we support Heritage's efforts to address this issue, we cannot accept Heritage's assertion of substantial compliance as a substitute for CPR and/or first aid certifications and maintain that our findings in this report are correct.

Attendants Serving as Attorneys-in-Fact

Heritage Comments

Heritage stated that none of the deficiencies for the sample items in the section "Missing State Agency Prior Approval for Personal Care Services Provided by Recipient's Legal Guardian or Attorney-in-Fact" constituted noncompliance with PCO regulations. According to Heritage, the claims in this category should have been allowable for the following reasons:

- The attendant was not the attorney-in-fact for the recipient on the date of service.

- The date of the attorney-in-fact document and date of hire for the attendant preceded the implementation of the 2004 New Mexico regulation that required prior State agency approval.

- Heritage was not aware of the attendant's attorney-in-fact or legal guardian status as of the date of service and is not responsible for individuals who fail to report their status.

- The initial attorney-in-fact designation was revoked and persons other than the attendant were appointed.

Heritage stated that after our audit, it had initiated a plan to ensure that approvals are obtained or that revocations are executed for all current employees who are a legal guardian or attorney-in-fact.

Office of Inspector General Response

We reevaluated our findings for the sampled items on which attendants served as attorneys-in-fact and reduced the deficiencies noted in the report for some claims but stand by our reported findings for others. Specifically:

- We agree that the attendant was not the attorney-in-fact for the recipient on the date of service. Rather, the attendant was designated as an "alternate" attorney-in-fact. Although NMAC section 8.315.4.11A(21) requires the State's prior approval for attendants designated as attorney-in-fact, it does not specify the process for obtaining approval for attendants designated as an alternate. As a result, we removed the deficiencies for those sampled items for which Heritage did not obtain prior approval for an attendant designated as an alternate and revised the draft report accordingly.

- State officials told us that attorney-in-fact documents existing before the 2004 regulations should have been submitted for approval within 60 days of the implementation date of the regulation. As of the date of our fieldwork, Heritage had not submitted these attorney-in-fact documents to the State agency.

- Heritage is responsible for monitoring its attendants' status to ensure that attorney-in-fact or legal guardian designations are reported immediately. For the sample items in question, the attorney-in-fact document was dated before the date of service; however, it was stamped as received by Heritage a few days later. Nevertheless, Heritage did not submit the document for State approval as of the time of our fieldwork, which was approximately 2 years after the date of service. The regulations require prior State agency approval for an attendant to be an attorney-in-fact for a recipient.

- We agree that the subsequent designations appointed persons other than the attendant as the attorney-in-fact. NMAC section 8.315.4.11A(21) does not specify a process to revoke prior designations. In addition, it is reasonable to infer that the most recent appointment could effectively revoke, or supersede, any prior appointments. As a result, we removed the deficiency for the sampled item for which Heritage had received subsequent attorney-in-fact documents and revised the draft report accordingly.

Training

Heritage Comments

Heritage stated that it had provided documentation for some of the sample items listed in the "Annual Training" section. In addition, Heritage said that it met the training requirements for 15 sample items involving training that occurred within 2 months of attendants' date-of-hire anniversary and that 11 other attendants had at least 9 hours of annual training, which was in substantial compliance with the annual training requirement.

Heritage stated in an affidavit that training for the general competency test should have been credited as 8 hours rather than 2 hours.

To ensure compliance with the regulations, Heritage stated that it has issued a policy requiring designated personnel to begin auditing annual training for completion and compliance.

Office of Inspector General Response

We reviewed the documentation that Heritage provided and determined that some claims complied with training requirements. We revised the report accordingly. However, Heritage's assertion of substantial compliance regarding other lapses with attendant training, including training that occurred within 2 months of attendants' date-of-hire anniversary and attendants who had at least 9 hours of annual training, is not justified. The types of deficiencies we reported, when taken as a whole, are sufficiently numerous and widespread to be considered more than just technical deficiencies. Additionally, Heritage's claim that we should credit those attendants who completed the general competency training with more training hours than Heritage originally granted based on its reevaluation of time to complete the training and topics covered is speculative at best and beyond the scope of our audit.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In its written comments on our draft report, the State agency disagreed that our findings support the recommended refund amount. The State agency said that four of the five categories of deficiencies (i.e., training documentation, CPR and first aid certification, tuberculosis testing, and prior approval of legal guardian) 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 these categories are not Federal requirements; they are State requirements, which do not require recovery of payments.

The State agency agreed that although one category (i.e., unsupported attendant service units) supports the conclusion that a single overpayment was made, this deficiency does not support

extrapolating the overpayment to all claims submitted during the 2-year review period. The State agency added that this finding is too isolated and is clearly an aberration from Heritage's normal practices. The State agency said that the overpayment was less than 0.2 percent of all claims reviewed in the audit, far less than the tolerance limits established in certain Federal programs.[11] The State agency added that in these programs, standard Federal policy in such circumstances is to seek recovery only for the overpayments identified and not to extrapolate the results.

The State agency also said that the Federal Government's requirement to recoup nearly 20 percent of the Federal funds Heritage received during the audit period is unreasonable because we reviewed only 100 claims, or less than 0.03 percent, of the 363,903 claims Heritage submitted during the audit period.

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 training, CPR and first aid certification, tuberculosis testing, and prior approval of legal guardianship, are based on significant service-related requirements. Taken as a whole, these deficiencies are too numerous to be dismissed as just a few missing documents, particularly because the deficiencies in question relate to quality of care.

We disagree that the documentation requirements in question for four of the five categories of deficiencies 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 identified other deficiencies based 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 Heritage's personal care services. As stated in New York State Department of Social Services, DAB No. 1358 (1992), "… sampling (and extrapolation from a sample) done in accordance with scientifically 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."

[11] 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).

The Heritage 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. [12] 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."[13] Courts have not determined how large a percentage of the entire universe must be sampled to be held valid;[14] however, the type of sample used here—a simple random sample—is recognized as a valid type of collection for extrapolation purposes.[15] Further, such statistical sampling and such a methodology may be used in cases seeking recovery against States and individual providers or private institutions alike.[16]

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.

Finally, if we had used a larger sample size, as the State agency comments imply we should have, the amount we recommended for recovery from Heritage probably would have been higher. A larger sample size usually yields estimates with better precision without affecting the estimate of the mean. Better precision would typically result in a larger lower limit for the confidence interval of the estimate. Therefore, had we used a sample size larger than 100, the estimated lower limit for the 90-percent confidence interval probably would have been a higher amount. Also, guidance provided in the CMS *Program Integrity Manual* (subsection 3.10.4.3, "Determining Sample Size") states: "A challenge to the validity of the sample that is sometimes made is that the particular size of the sample is too small to yield meaningful results. Such a challenge is without merit …."

The State agency did not provide any additional information that would lead us to change our findings or recommendations.

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[12] 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 Social Security 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).

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

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

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

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

OTHER MATTER

In reviewing supporting documentation for 27 of the 100 sampled items, we found that Heritage had charged $542 for time that the attendants billed for 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 services covered under the New Mexico personal care services program that are a normal division of household chores provided by a personal care attendant who resides with the beneficiary.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of personal care services claim lines submitted by Heritage Home Healthcare (Heritage) 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 363,903 personal care services claim lines (totaling $22,454,952) for the period October 1, 2006, through September 30, 2008.

SAMPLE UNIT

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

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 363,903. 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)
363,903	$16,058,247	100	$4,347	36	$1,605

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

Point estimate	$5,840,861
Lower limit	$4,483,492
Upper limit	$7,198,231

APPENDIX C: REASONS FOR DEFICIENT CLAIM LINES

1	Missing evidence of annual training
2	Missing evidence of cardiopulmonary resuscitation and/or first aid certifications
3	Missing evidence of tuberculosis testing
4	Missing prior State agency approval for personal care services provided by a legal guardian or attorney-in-fact
5	Unsupported units of payment

No.	1	2	3	4	5	No. of Deficiencies	Sample Item No.[1]
1			X			1	3
2	X				X	2	9
3	X	X				2	12
4	X					1	15
5	X					1	18
6	X			X		2	19
7	X					1	23
8	X					1	24
9	X					1	26
10	X					1	27
11	X					1	30
12				X		1	34
13	X					1	37
14	X					1	38
15	X					1	39
16	X					1	40
17	X					1	51
18	X					1	55
19	X					1	56
20	X	X				2	58
21	X					1	59
22		X				1	62
23	X					1	63
24	X					1	64
25	X					1	65
26	X					1	66
27	X					1	72
28	X					1	74

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

No.	1	2	3	4	5	No. of Deficiencies	Sample Item No.
29	X					1	81
30				X		1	88
31				X		1	90
32	X					1	91
33		X				1	92
34		X				1	96
35		X		X		2	97
36	X					1	98
Total	**28**	**6**	**1**	**5**	**1**	**41**	

Total deficiencies for “Attendant Qualification Deficiencies” (columns 1 through 3) is 35. The total for “Other Deficiencies” (columns 4 and 5) is 6.

APPENDIX D: HERITAGE COMMENTS

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October 1, 2010

File No. 1805-001

VIA EMAIL & OVERNIGHT DELIVERY
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Re: Heritage Home Healthcare and Hospice
OIG Report Number A-06-09-00063

Dear Ms. Wheeler,

We represent Heritage Home Healthcare and Hospice ("Heritage"), and write in response to your letter to Mr. Len Trainor dated July 26, 2010, enclosing the U.S. Department of Health & Human Services, Office of Inspector General's (the "OIG") Draft Report entitled *Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare* (the "Draft Report"). As explained in this letter, Heritage disputes many of the OIG's findings contained in the Draft Report, as well as the OIG's recommendation for recoupment.

I. Global Concerns Regarding the Draft Report and Recommendations

Heritage has three global concerns regarding the Draft Report and its findings and recommendations. First, the Draft Report almost exclusively addresses alleged deficiencies of conditions of participation; however, the Draft Report recommends recoupment, which is appropriate only for violations of conditions of payment. Second, the Draft Report fails to acknowledge Heritage's substantial compliance with the New Mexico Personal Care Option regulations (the "PCO regulations"). Heritage's substantial compliance with these regulations, particularly as they have been interpreted by the New Mexico agency that promulgated them, makes it inappropriate for the OIG to recommend recoupment. This is especially true because the Draft Report makes no suggestion and provides no evidence that any of the alleged deficiencies were fraudulent. Third, the sampling of claim lines and the Draft Report's extrapolation therefrom is methodologically unsound and unprecedented in New Mexico, and therefore does not support the OIG's recoupment recommendation.

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a. Conditions of Payment v. Conditions of Participation

The Draft Report alleges that Heritage was deficient as to several PCO regulations and recommends recoupment of Medicaid dollars. Recoupment is *not*, however, an appropriate remedy for the alleged deficiencies because compliance with the PCO regulations is not a condition of payment; it is a condition of participation. Conditions of participation are those requirements providers must meet in order to participate in the Medicaid program. Courts have frequently held, in the False Claims Act context, that a provider is not liable for repayment or recoupment for failures to comply with government regulations "unless, as a result of such acts, the provider knowingly asked the government to pay amounts it did not owe."[1]

For example, the Kansas District Court, which, like New Mexico, is in the Tenth Circuit, observed:

> To allow FCA suits to proceed where government payment of Medicare claims is not conditioned on perfect regulatory compliance-and where HHS may choose to waive administrative remedies, or impose a less drastic sanction than full denial of payment-would improperly permit qui tam plaintiffs to supplant the regulatory discretion granted to HHS under the Social Security Act, essentially turning a discretionary denial of payment remedy into a mandatory penalty for failure to meet Medicare requirements.[2]

In affirming the Kansas District Court, the Tenth Circuit further explained that "[e]ven if, as the result of the survey, a provider appears noncompliant, the government does not immediately suspend Medicare enrollment or billing privileges. Rather, the relevant regulations permit the provider to create a plan of correction, and allow a reasonable period of time-usually 60 days-to address any deficiencies."[3] The Tenth Circuit also noted that there are no regulations or case law "indicating that the government normally seeks retroactive recovery of Medicare payments for services actually performed on the basis that the noncompliance rendered them fraudulent."[4]

The same is true here. First, Heritage did not seek payment from the New Mexico Human Services Department ("HSD") for types of services that Medicaid does not cover and all services for which Heritage sought reimbursement were provided to Medicaid beneficiaries as claimed.

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[1] *E.g., U.S. ex rel. Williard v. Humana Health Plan*, 336 F.3d 375, 381-85 (5th Cir. 2003).

[2] *U.S. ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 459 F.Supp.2d 1081, 1087 (D. Kan. 2006), aff'd 543 F.3d 1211 (10th Cir. 2008).

[3] *U.S. ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 543 F.3d 1211, 1220-21 (10th Cir. 2008).

[4] *Id.*

Moreover, with minor exceptions, Heritage adhered to the provisions HSD's Medical Assistance Division ("MAD") provider participation agreement and all applicable statutes, regulations, billing instructions and executive orders. Second, as discussed further below, Heritage conducted an internal review, created a plan of correction, and addressed all deficiencies noted by the OIG. Third, while state regulations list numerous criteria related to the coverage of personal care option services under the Medicaid program, none of those criteria require compliance with the consumer-delegated PCO regulations as a condition of reimbursement.[5]

Reviewing the regulation as a whole, we could not find support for the position that payment for services is conditioned upon compliance with every subsection of the PCO regulations at NMAC 8.315.4.11A. The only discussion of recoupment is contained at NMAC 8.315.4.11(A)(14). This subsection states that PCO agencies must pass random and targeted audits, conducted by HSD or its audit agent to ensure that the agencies are billing appropriately for services rendered. The regulation also expressly states that "the department or its designee will seek recoupment of funds from agencies when audits show inappropriate billing for services."[6] Therefore, the only basis for recoupment provided for in the PCO regulations arises solely when a provider has inappropriately billed for services. With one very limited exception discussed below, this basis for recoupment is in no way triggered by the various alleged deficiencies outlined in the Draft Report. Indeed, historically, HSD has used corrective action plans, sanctions or a combination of both – but *not* repayment - to address providers' deficiencies as to conditions of participation, like the vast majority of those identified in the Draft Report.[7] We understand that this remains HSD policy.

b. Substantial Compliance

At all times during the audit period, Heritage was in substantial compliance with the PCO regulations. For Medicaid survey and certification purposes, "substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."[8] Moreover, as the Tenth Circuit has observed, "although the government considers substantial compliance a condition of ongoing Medicare *participation,* it does not require perfect compliance as an absolute

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[5] NMAC 8.315.4.13, 8.315.4.14.

[6] NMAC 8.315.4.11(A)(14).

[7] *See* NMAC 8.351.2 (Sanctions and Remedies). It is worth noting again here that the Draft Report makes no suggestion and presents no evidence suggesting that any of the alleged deficiencies are due to any fraudulent conduct by Heritage. Therefore, even under the available sanctions and remedies available to HSD for violations of conditions of participation, the penalties to which Heritage would be subject to remain limited and do not come anywhere close to the magnitude of the recommendation in the Draft Report.

[8] 42 C.F.R. § 488.301.

condition to receiving Medicare *payments* for services rendered."[9] The same is equally true here as to Medicaid participation and payments – perfect compliance is *not* necessary. Importantly, at no time was the health or safety of any client at risk nor was care rendered in such a manner that would cause harm to Heritage's clients.

Finally, the OIG failed to apply a reasonableness standard to compliance with the regulations. First, New Mexico's regulations are comprehensive and are intended to provide policies related to the operation of the Medicaid program, including those regarding provider eligibility, covered and non-covered services, utilization review, and provider reimbursement.[10] The OIG based its recommendation on six out of 38 requirements in the regulations. Even accepting this selection, however, the Draft Report wholly fails to acknowledge that Heritage did have a 90 percent or better compliance rate for nearly every one of the six categories.[11] Second, the OIG has not demonstrated that strict adherence to every aspect of the regulation at issue guarantees better care for clients.[12] Moreover, many of the technical deficiencies that were noted relate to requirements that HSD does not impose on personal care attendants in other settings, i.e. the consumer-directed care model.[13] Certainly Heritage's clients would have been at a greater risk of harm by not receiving services at all. We believe that Heritage was in substantial compliance with the spirit and intent of NMAC 8.315.4.11A.

c. Sampling and Extrapolation

The Draft Report relies on a sampling of 100 out of 363,903 claim lines, and then makes a recommendation for recoupment using an extrapolation ratio of 1 to 3,639. This sort of

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[9] *U.S. ex rel. Conner,* 543 F.3d at 1221 (emphasis in original). Case law in New Mexico is consistent with the position of the federal court. For example in *Gutierrez v. City of Albuquerque*, 631 P.2d 304, 307 (N.M. 1981), the Supreme Court of New Mexico stated that "[s]ubstantial compliance has occurred when the statute has been sufficiently followed so as to carry out the intent for which it was adopted and serve the purpose of the statute." And, in *Lane v. Lane*, 919 P.2d 290, 295 (N.M. Ct. App. 1996), the New Mexico Court of Appeals stated that "[t]he legislature can . . . expect that when one of its orders (i.e, a law) is to be carried out, those who have that duty (i.e., the courts) will discern its purpose and act in accordance with its essence if not necessarily its letter."

[10] NMAC 8.315.4.6.

[11] *See infra.*

[12] As one example of what such a reasonable standard would entail, we note that the New York Office of the Medicaid Inspector General ("OMIG") has reviewed the matter of substantial compliance with regard to training in the home health arena. In draft guidance, the OMIG instructed that disallowances should not be taken "if the provider has decent controls in place and, in a couple of situations, the aide was short a few hours – especially when they have documented some reasonable explanation." Available at http://www.hca-nys.org/documents/CHHAOMIGProtocols.pdf. We believe the OIG should take a similar position here.

[13] *See* NMCA 8.315.4.10(B)(11)(2004).

extrapolation is unprecedented in New Mexico. Historically, HSD does not extrapolate from its audit findings. To our knowledge, this is equally true of the other New Mexico Departments. This is likely because the New Mexico regulations do not support extrapolation.

Even if extrapolation was permissible and supported by New Mexico regulations, Heritage disputes the statistical validity of both the sample size and the extrapolation in the Draft Report. The OIG's statistical analysis suffers from *prima facie* errors that render it incapable of supporting the Draft Report's recommendations. First, because the audit did not rely on a valid statistical procedure, the resulting sample is not statistically valid. The OIG appears to have chosen a sample of 100 claims, not based on any statistical analysis of the variance or heteroskedasticity of the pool (which is the ordinary procedure for statistical sampling), but instead appears to have chosen 100 sample claims based on the assumption that this would be sufficient and, perhaps, based on the simplicity of using a round number.[14] This is contrary to well-accepted statistical methodology as well as the guidance provided in the CMS Program Integrity Manual.[15]

Second, OIG's 0.0275 percent sample rate is insufficient to support its conclusions. The records for a company with approximately 702 attendants,[16] 848 clients, and 363,903 claims during the sample period would be expected to naturally exhibit significant variance. Indeed, the results demonstrate the intrinsic variability of the sample and the need for additional sampling. No court appears to have ever confronted such unreliable statistical analysis in a similar setting; courts have dealt only with *actual* statistical sampling that resulted in sampling rates typically between 5 percent and 10 percent, and only as low as 0.7 percent.[17] Indeed, traditional sampling estimates for this type of data – even assuming that the population was not highly variable – require a sample rate

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[14] We note that the OIG habitually selects a sample size of 100 claims without regard to the number of claims in the universe. For example: "Review of Personal Care Services Claimed by the Center for Living and Working, Inc.," (A-01-06-00011), sample size= 100, universe= 4,466 payment years; "Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 Through September 30, 1999," (A-05-01-00044), sample size= 100, universe= 211,000 claims.

[15] CMS Medicare Program Integrity Manual, Ch. 3 § 3.10.

[16] This number is as of April 1, 2010.

[17] *See Goldstar Medical Servs., Inc. v. Dept. of Soc. Servs.*, 955 A.2d 15 (Ct. 2008) (2.7% sample rate); *Harris v. Bernad*, 275 F. Supp. 2d 1 (D.D.C. 2003) (0.7% sample rate); *Pruchniewski v. Leavitt*, 2006 WL 2331071 (M.D. Fla. 2006) (5% sample rate); *Scottsdale Mem'l Health Sys., Inc. v. Maricopa County*, 228 P.3d 117 (Ariz. Ct. App. 2010) (reaching a 95% confidence interval to 6% sample rate); *Chaves County Home Health Serv., Inc. v. Sullivan*, 931 F.2d 914 (D.C. Cir. 1991) (10% and 3% sample rates); *Ill. Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982) (27% sample rate).

of *at least* 2 percent.[18] Here, the high variable and extremely small sample size yields unreliable results when extrapolated to the universe of claims.[19]

Following the OIG's audit, Heritage conducted its own 100 percent review of the personnel files of its 702 homemakers, personal care attendants, and home health aides. Heritage's review supports the conclusion that the OIG's statistical analysis is invalid. For example, out of the 702 files, Heritage found that only ten, or 1.4 percent of the files, were missing evidence of CPR certification. However, the OIG's analysis led to a conclusion that 9 percent of the claims involved insufficient CPR certification. This example, coupled with the methodological problems in the Draft Report's statistical analysis, demonstrates that extrapolation across the universe yields an inappropriate result.

II. Categories of Compliance

In addition to the concerns above, many of the Draft Report's factual findings are exaggerated and factually inaccurate. The Draft Report identified six areas in which it alleges Heritage is missing evidence that the services provided complied with the PCO regulations. These areas are units claimed, criminal background checks, tuberculosis testing, first aid and cardiopulmonary resuscitation ("CPR") certifications, and services provided by legal guardians or attorneys-in-fact. The issues raised by the Draft Report in each of these categories of compliance are addressed below in detail.

a. Units Claimed

Only one out of 100 sample item numbers (number 9) was identified in the Draft Report as having "Unsupported Units Claimed." Contrary to the suggestion in the Draft Report, we believe Heritage's 99 percent compliance with the PCO regulation's requirement for full documentation of services rendered to be reasonable. This is especially true when considering the alleged deficiency with sample item nine, i.e. that one hour of recorded time (out of a week of nearly 30 hours) is at issue. Notwithstanding, Heritage does not dispute that the one hour of time captured in sample item nine that was recorded on April 29, 2007, was mistakenly billed under the PCO regulations because, as set forth on the timecard, the client was in the hospital during that one hour. Because Heritage

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[18] *See, e.g.,* James E. Bartlett, II, et al., *Organizational Research: Determining Appropriate Sample Size in Survey Research,* Information Technology, Learning and Performance Journal, Vol. 19, No. 1, Spring 2001 at 43.

[19] It is unclear from the Draft Report whether the OIG used RAT-STATS for selecting its statistical sample. The Draft Report states only that "Office of Inspector General, Office of Audit Services statistical software" was used "to generate random numbers" and "to estimate the total value of overpayments." We believe we are entitled to a fair opportunity to examine the software. If the OIG is referring to a program other than RAT-STATS, we should have the opportunity to review and evaluate the program to determine whether it can produce a statistically valid sample.

acknowledges that this time was mistakenly billed, Heritage is voluntarily repaying the $12.28 it was paid for this one hour in dispute.

Heritage does not believe, however, that the mistake captured in sample item nine constitutes any more than a clerical mistake. The facts demonstrate that the billing of one hour when the client was institutionalized was in no way a willful or fraudulent act by Heritage. Indeed, the attendant wrote on the relevant timecard that the client was institutionalized on April 29, 2007, during the one hour of recorded time. It is Heritage's policy to pay attendants for their time in these sorts of situations, which is what Heritage did in this instance. Due to a clerical mistake, however, the one hour was also billed to Medicaid. By way of explanation, another Heritage payor does pay for time spent by an attendant despite institutionalization of the client if the attendant and Heritage were unaware of the institutionalization when the attendant was sent to the client's home. Heritage believes that the one hour identified in sample item nine likely was accidentally billed with this other payor's policy in mind.

Nonetheless, to ensure that there are no other instances where Heritage billed for an attendant's time when the client was institutionalized, Heritage voluntarily initiated a 100 percent review of all timecards from August 1, 2008, through August 31, 2010, for this issue. Heritage anticipates that it will complete its internal audit in November 2010 and, upon completion, will repay any identified amounts that were received for an attendant's time during a client's concurrent institutionalization.

b. Criminal Background Checks

Only one out of 100 claims was identified in the Draft Report as "Missing Evidence of Criminal Background Checks." This sample item was number 76. However, as demonstrated in the sample-by-sample binders[20], Heritage is 100 percent compliant with the criminal background check requirement. Specifically, since receiving the Draft Report, Heritage has located the letter from the New Mexico Department of Health, dated May 13, 2002, notifying Heritage that the attendant for number 76 had "no disqualifying convictions" and providing final clearance for the attendant to work as a PCO attendant.

[20] Three binders were sent via overnight delivery by cover dated September 30, 2010. These binders are entitled (1) Sample-by-Sample Documentation, vol. 1; (2) Sample-by-Sample Documentation, vol. 2; and (3) General Competency Training. The binders are referenced throughout this letter and were submitted as additional documentation to support Heritage's findings. To the extent the contents of the binders are subject to the Freedom of Information Act ("FOIA"), they are protected from release under FOIA exemptions (b)(4), (b)(6) and (b)(7).

c. Tuberculosis

The Draft Report identified 13 files with "Missing Evidence of Tuberculosis Testing." These 13 files correspond with sample item numbers 3, 19, 27, 37, 39, 50, 54, 55, 77, 86, 88, 91 and 98. Since your last correspondence with Heritage, we have located the attendant's original tuberculosis test results corresponding to sample item numbers 27, 54, 55 86, and 88. These original tuberculosis test results are included in the sample-by-sample binders. These results reduce the number of files at issue as to tuberculosis testing to eight.

For five of the remaining eight, i.e. numbers 3, 50, 77, 91 and 98, we believe the files do contain sufficient "Evidence of Tuberculosis Testing" because they contain tuberculosis questionnaires. It was Heritage's routine business practice to administer tuberculosis questionnaires to attendants only after the attendant had been tested for tuberculosis. Indeed, a reminder to obtain a tuberculosis questionnaire was only entered into the Heritage database after the original tuberculosis test or x-ray results were received. Heritage's routine practice of obtaining tuberculosis questionnaires only for those attendants for whom it had already received a negative tuberculosis test result demonstrates that Heritage did, in fact, have negative test results for sample item numbers 3, 50, 77, 91 and 98. "Evidence of . . . the routine practice of an organization . . . is relevant to prove that the conduct of the . . . organization on a particular occasion was in conformity with the habit or routine practice."[21] This type of routine practice, importantly, is not "a second-class category" of evidence; it is evidence equal to that of any other form.[22]

In *In re Swine Flu*, for example, the court heard testimony that the Jefferson County Health Department had a routine practice of obtaining signed consent forms prior to administering a vaccine.[23] Despite this routine practice, there were no signed consent forms located or presented by the Jefferson County Health Department for the date on which the plaintiff received her vaccine, and when the plaintiff claimed she did not provide signed, informed consent.[24] Faced with this evidence and the missing signed consent form by plaintiff, the court held that the Jefferson County Health Department's routine practice evidence established that it had obtained written, informed consent from the plaintiff on the date in question.[25]

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[21] Fed. R. Evid. 406.

[22] *In re Swine Flu Immunization Prod. Liab. Litig.*, 533 F. Supp. 567, 573 (D. Colo. 1980) (quotation omitted); *see also Meyer v. United States*, 464 F. Supp. 317, 320-21 (D. Colo. 1979) (holding that a dentist's practice on a particular occasion conformed with his routine practice of obtaining informed consent, despite directly contradictory testimony of the patient-plaintiff).

[23] 533 F. Supp. at 574.

[24] *Id.* at 573.

[25] *Id.* at 573-74.

The court's analysis and decision are equally applicable here. Admittedly, Heritage cannot provide the original negative tuberculosis test results for sample item numbers 3, 50, 77, 91 and 98. It can and has, however, provided evidence that it has tuberculosis questionnaires for each of the attendants for these sample items, and that its routine practice was not to administer these questionnaires to attendants unless a negative tuberculosis test result or x-ray reading already had been received. According to the Federal Rules of Evidence, this is sufficient evidence that Heritage did indeed have negative tuberculosis test results for sample item numbers 3, 50, 77, 91 and 98. This brings the number of files at issue as to tuberculosis testing to three.

Of the remaining three, we believe that two cannot be treated as deficiencies because they relate to attendants who were hired prior to the effective date of the 2004 PCO regulations and, thus, prior to the tuberculosis testing requirement contained therein. The corresponding sample numbers for attendants hired prior to the tuberculosis testing requirement are numbers 37 and 39. Under the 2004 PCO regulations, PCO agencies were required to "obtain[] a current tuberculosis (TB) skin test or chest x-ray upon initial employment."[26] Under the Original PCO regulations, however, there was no requirement for PCO agencies to obtain or maintain documentation of attendants' tuberculosis testing upon initial employment.[27] Importantly, as to tuberculosis testing, the effective date for the 2004 PCO regulations was July 1, 2004 (the "2004 PCO regulation's Effective Date").[28] The attendants for sample item numbers 37 and 39 were hired on March 17, 2004, and September 29, 2000, respectively.[29]

Moreover, under New Mexico law, the 2004 PCO regulations' tuberculosis testing requirement was not retroactive. "New Mexico law presumes that statutes and rules apply prospectively absent a clear intention to the contrary."[30] This rule applies even more so when the change in the statute or regulation is "not a mere change in procedure, but a change affecting substantive rights; and, as to such statutes, the rule is well settled that they will not be given a

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[26] NMAC 8.315.4.11(A)(37) (2004).

[27] *See generally* NMAC 8.4.738 (2000).

[28] NMAC 8.315.4.5 (2004).

[29] Note that sample item numbers 50, 77 and 91 also correspond with attendants hired before the effective date of the 2004 PCO regulations, and thus the tuberculosis testing requirement contained therein. The attendants for sample item numbers 50, 77 and 91 were hired on July 13, 2003; March 3, 2004; and December 11, 2001, respectively. It appears from the files of these attendants, however, that Heritage did obtain negative test results because, as discussed above, Heritage has documentation of tuberculosis questionnaires from these attendants. Should OIG determine that these questionnaires are insufficient evidence of the attendants' negative tuberculosis testing results, despite the business practice evidence to the contrary, then sample item numbers 50, 77 and 91 still should not be treated as deficiencies because, like sample item numbers 37 and 39, they correspond with attendants hired before the tuberculosis testing requirement became effective.

[30] *Howell v. Heim*, 118 N.M. 500, 882 P.2d 541 (N.M. S. Ct. 1994) (citation omitted).

retroactive effect unless it clearly appears that the Legislature so intended."[31] Here, the requirement for tuberculosis testing added by the 2004 PCO regulations was a substantive change, not a procedural one, and there is no indication in the relevant portions of the 2004 PCO regulations that this substantive change was to apply retroactively. Therefore, the New Mexico presumption against retroactive application of regulations and statutes controls and attendants hired prior to the 2004 PCO regulations' Effective Date did not have to be retroactively tested for tuberculosis.

Finally, we believe it is important to note that despite any discrepancies alleged by the OIG, the quality and safety of Heritage's services were not diminished. This is particularly true in light of the absence of any requirement for tuberculosis testing of attendants providing Personal Care Option services under the Consumer-Directed model.[32] Nonetheless, as part of its efforts to ensure that Heritage provides quality and safe services to its clients, Heritage sought and obtained negative test results for the attendants identified in the OIG audit that were still employed by Heritage, but for whom Heritage did not locate their original negative test results.

Sample Item No.	Date of Hire	Date of Service	Date of Termination	Post-Audit Test Results
3	9/27/06	12/1/07	4/13/09	NA
19	9/21/05	8/5/07	2/27/08	NA
37	3/17/04	11/21/06	5/28/07	NA
39	9/29/00	11/12/06	10/16/07	NA
50	7/13/03	1/20/08	7/24/08	NA
77	3/3/04	12/14/07	11/18/09	NA
91	12/11/01	3/15/07	NA	12/28/09
98	5/25/05	3/4/07	NA	8/2/10

[31] *Wilson v. New Mexico Lumber & Timber Co.*, 42 N.M. 438, 81 P.2d 61, 63 (1938) (quotation omitted).

[32] *See* NMCA 8.315.4.10(B)(11) (2004).

The results of the additional tests for the attendants still with Heritage reveal that none of these attendants have tuberculosis. For reference, these test results are included in the sample-by-sample binders.[33]

d. CPR/First Aid Certifications

The Draft Report identified nine out of the 100 sampled claims for which Heritage is allegedly "Missing Evidence of [CPR] and First Aid Certifications." These sample item numbers are 12, 31, 37, 58, 62, 84, 92, 96 and 97. Since receiving the Draft Report, Heritage has located sample item number 84's CPR and First Aid Certifications for the Date of Service at issue. Documentation of these certifications is contained in the sample-by-sample binders. This brings the total number of sample items at issue to eight. We strongly believe that Heritage's 92 percent compliance as to CPR and First Aid Certifications demonstrates substantial compliance with the PCO regulations.[34] This is particularly true because, for at least six out of the remaining eight sample items identified in the Draft Report, the attendant was competent to provide CPR and First Aid to the client if needed.[35]

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[33] In addition to Heritage's efforts as to the attendants identified by the Draft Report, this year Heritage also performed a 100 percent audit of its personnel files as to tuberculosis test documentation. In response to that internal audit, Heritage sought and obtained tuberculosis tests for those employees whose files did not contain an original, negative tuberculosis test. All of the tests were negative except one for an attendant who was subsequently cleared via x-ray.

[34] We have determined that Heritage's current compliance with the CPR and First Aid Certification requirements in the PCO regulations is, in fact, much higher than 92 percent. On April 1, 2010, Heritage initiated a file audit of the 702 then-current Homemakers, Personal Care Attendants, and Home Health Aids in its employment. As a part of that audit, Heritage verified the existence and/or validity of over 51,948 documents, 47,736 of which were in the employees' files. In this comprehensive audit, Heritage determined that only 1.4 percent of its employee files were missing the necessary CPR and/or First Aid Certifications. By this count, Heritage is in 98.6 percent compliance with the regulations on CPR and First Aid Certifications; an extremely high compliance rate.

[35] The attendants for these six sample items already had received CPR and First Aid certifications that, while lapsed during the Date of Service at issue, were thereafter renewed.

Sample Item No.	Date of Service	Prior Certification Period	Subsequent Certification Period
12	9/22/07	1/05 to 1/07	10/08 to 10/10
31	9/12/07	7/04 to 7/06	10/08 to 10/10
62	3/26/08	1/06 to 1/08	4/08 to 4/10
92	1/7/08	3/05 to 3/07	3/08 to 3/10

Finally, it should be noted that the attendant for sample item number 58 did have her CPR Certification for the date of service at issue in the Draft Report. And, while that attendant did not have First Aid Certification at the time of the Date of Service, the attendant did subsequently obtain that Certification. Taken together, it is clear that Heritage can demonstrate substantial compliance with the CPR and First Aid Certification requirements of the PCO regulations, and that Heritage's clients receive their care from competent, appropriately trained attendants. Nevertheless, Heritage voluntarily has taken efforts to improve its compliance rate as to CPR and First Aid Certifications to 100 percent. Effective as of April 2010, Heritage has instructed its records supervisor, office supervisor and executive director to ensure that attendants will not be scheduled for work absent effective proof of current CPR and First Aid Certifications. As a double-check, the office supervisor will also review the attendants scheduled to work every week to confirm each has current CPR and First Aid Certifications.

e. Attendants Serving as Attorneys-in-Fact

The Draft Report identified eight sample item numbers as allegedly deficient because of "Missing Evidence of Services Provided by Legal Guardian or Attorney-in-Fact." These alleged deficiencies relate to Heritage's purported failure to obtain prior approval from the MAD for the attendants to serve as a legal guardian or attorney-in-fact to the clients for sample item numbers 19, 34, 39, 62, 88, 90, 93 and 97. Preliminarily, it should be noted that both sample item numbers 34 and 90 relate to one attendant-client pair, and both sample item numbers 62 and 93 relate to another attendant-client pair. Thus, the Draft Report's deficiencies in this area only relate to six legal guardian/attorney-in-fact attendant-client pairs.

As to these six pairs, none of the alleged deficiencies constitute Heritage's failure to comply with the PCO regulations. First, as to sample item numbers 62 and 93, the attendant was not the attorney-in-fact for the client until April 21, 2009, which was after both the Dates of Service at issue in the audit, i.e. March 26, 2008 and August 18, 2007. Therefore, Heritage could not have obtained approval of the attendant's appointment as attorney-in-fact before the Date of Service because the Power of Attorney was not yet in existence.

96	9/4/07	3/05 to 3/07	11/07 to 11/09
97	10/12/07	2/05 to 2/07	11/07 to 11/09

The lapse of a formal certification should not be taken as an indication that Heritage clients received substandard care because the Consumer-Directed model of the Personal Care Option program does not require attendants to be CPR and First Aid Certified. NMCA 8.315.4.10(B)(11) (2004). Lapsed certification does not translate into a presumption that the care the attendant provided was substandard.

Second, as to sample item numbers 88 and 97, Heritage received the relevant Power of Attorney document before the 2004 PCO regulations Effective Date, i.e. Heritage received the Power of Attorney documents on January 12, 2004, and September 9, 2003, respectively. As to sample item numbers 34, 39 and 90, Heritage also received or likely received the Power of Attorney document before the 2004 PCO regulations Effective Date based on the various dates of each document and the Date of Hire for the particular attendant. These are:

Sample Item No.	Date of Hire	Date on POA
34	5/21/02	10/23/1999
39	9/29/00	1/18/2001
90	5/21/02	10/23/1999

Heritage's receipt of the relevant Power of Attorney documents for sample item numbers 34, 39, 88, 90 and 97 before the 2004 PCO regulation's Effective Date is significant because the Original PCO regulations did not contain any requirement for PCO agencies to obtain approval as to attendants simultaneously serving as the client's legal guardian or attorney-in-fact.[36] Therefore, when Heritage received the Power of Attorney documents for sample item numbers 34, 39, 88, 90 and 97, Heritage was under no obligation to obtain approval for the attendant-client pairings. And, when the new approval requirement was placed in the 2004 PCO regulations, the new approval requirement did not suggest or otherwise indicate that the new requirement was retroactive.[37] As discussed above, because the new approval requirement is substantive, not merely procedural, and there is no clear intent in the Regulations suggesting that the approval requirement be applied retroactively, the approval requirement is prospective only under New Mexico law.[38]

Third, as to sample item numbers 19 and 39, Heritage was not aware of the attendant's status as the client's legal guardian/attorney-in-fact on the Date of Service. As explained below, under these circumstances, pursuant to New Mexico law, Heritage is not responsible for these individuals' failure to report their status. For sample item number 19, Heritage was not provided with or made aware of the attendant's Power of Attorney document until after the Date of Service. The relevant dates are:

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[36] *See* NMAC 8.4.738 (2000).

[37] *See generally* NMAC 8.315.4.11(A)(21) (2004).

[38] *Howell, supra*, 118 N.M. 500; *Wilson, supra*, 42 N.M. 438.

Sample Item No.	Date of Service	Date POA Received
19	8/5/07	8/31/07

A client's and/or attendant's failure to notify Heritage of a Power of Attorney prior to the Date of Service cannot form the basis for a deficiency under the PCO regulations as to Heritage. As held by the Ninth Judicial District Court of New Mexico, an employer cannot be held liable for regulatory infractions by its employees absent some showing that the employees' infraction rose to the level of a felony criminal wrongdoing.[39] With this standard in mind, Heritage cannot be held liable for its failure to obtain prior approval from MAD for sample item number 19 when it had no knowledge prior to the Date of Service that the attendant was also serving as the client's Attorney-in-Fact.

As to sample item number 39, it was Heritage's belief that the Power of Attorney applicable to the attendant had been revoked before the Date of Service because Heritage had received Power of Attorney documents appointing other persons as the client's attorney-in-fact before the Date of Service. The relevant dates are:

Sample Item No.	Date of Service	Date of First POA	Date of Second POA	Date of Third POA
39	11/12/06	1/18/01	9/27/04	10/20/05

While legal research has revealed that the subsequent Power of the Attorney documents did not function to revoke the Power of Attorney document naming the attendant, Heritage believed in good faith that it received the 2004 and then 2005 Power of Attorney documents, in part, to demonstrate the revocation of the 2001 Power of Attorney naming the attendant.

When considering this category of alleged deficiencies, it is particularly important to note the rationale behind this particular regulation. We understand that the 2004 PCO regulations' requirement for pre-approval of attendants serving as Legal Guardians or Attorneys-in-Fact was intended to avoid a circumstance in which an attendant would fraudulently certify his or her own timecard by virtue of simultaneously serving as the client's Legal Guardian or Attorney-in-Fact. In none of the sample item numbers at issue here did this occur. The timecards for each of the sample item numbers identified above demonstrate that the client or a different Legal Guardian or Attorney-in-Fact certified the attendant's timecard, and the attendant was never the one certifying.

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[39] *Town & Country Food Stores, Inc. Licensee v. New Mexico Regulation & Licensing Dept.,* D-0905-CV-00200900670, etc., at p. 3 (9th Jud. Dist. Crt. May 13, 2010).

We believe this is important because it demonstrates that Heritage was not only in compliance with the express requirements of the PCO regulations, but also with the policy behind them.

While disputing the findings in the Draft Report and the implications suggested therein, Heritage remains committed to complying with the PCO regulations and thus voluntarily initiated a corrective action plan in March 2010, and then amended it in April 2010, as to, among other things, legal guardian and attorneys-in-fact attendant-client pairs. Under this Plan, Heritage charged its care coordination managers and executive director to ensure that MAD approval was obtained for all attendant-client pairs still with Heritage, or that a revocation of the Power of Attorney naming the attendant was executed. As to the attendant-client pairs identified in the Draft Report, the results of this Plan were as follows:

Sample Item No.	Date of POA	Date of Termination	Revocation or Approval & Date
19	3/18/07	2/27/08	NA
34	10/23/99	NA	Revoked – 6/30/09
39	1/12/01	10/6/07	NA
62	4/21/09	NA	Revoked – Dated 3/11/10; Received 6/2/10
88	1/12/04	NA	Approved – 7/10/09
90	10/23/99	NA	Revoked – Received 6/30/09
93	4/21/09	NA	Revoked – Dated 3/11/10; Received 6/2/10
97	9/9/03	NA	Approved – 6/26/09

With this, Heritage ensured 100 percent compliance with the spirit and text of the 2004 PCO regulations. To ensure continued compliance with the PCO regulations, Heritage has also added a question to its telephone pre-screening form for prospective attendants that asks whether they are the attorney-in-fact for the respective Heritage client.

f. Training

The Draft Report identified 37 sample item numbers with allegedly "Missing Evidence of Annual Training." The then-applicable 2004 PCO regulations required that attendants receive 12

hours of training per year. Since the audit was completed, Heritage has located documentation of annual training for the Anniversary Period at issue for sample item numbers 11, 22, 53, 68, 73, 89, 90, and 97. The supporting documentation for these sample item numbers is included in the sample-by-sample binders. While some of this documentation is straightforward, others require comment, i.e. sample item numbers 11, 73 and 89. As to numbers 11 and 89, while some of the training occurred prior to the Anniversary Periods, those trainings also occurred prior to the attendants' Dates of Hire. Therefore, these trainings are properly attributable to the Anniversary Periods at issue.

Sample Item No.	Date of Hire	Anniversary Period	Date of Trainings Outside Anniversary Period
11	4/17/06[40]	4/17/06 to 4/16/07	4/5/06 and 4/6/06
89	7/11/07	7/11/07 to 7/10/08	7/6/07

As to number 73, note that while only one of the general competency tests is dated December 17, 2007, all of those tests uniquely are graded in green and are therefore believed to be completed and graded at the same time, i.e. within the Anniversary Period. Similarly, none of the EPSDT modules completed by the attendant at issue with sample item number 73 are dated. But, the date stamped on module 21, like the date on the general competencies for this attendant, is for December 12, 2007, and because all modules were written in black ink and graded in green ink, Heritage believes they were all completed on December 12, 2007, i.e. within the Anniversary Period.

Accordingly, the number of alleged discrepancies as to training is reduced to 29. Of this number, 15 should not be treated as deficiencies because the requisite 12 or more annual training hours are attributable to the Anniversary Period at issue, even if they did not occur within the technical bounds of that period. That is, as to some of the below trainings, the attendant completed 12 hours or more of annual training attributable to a given Anniversary Period, but which actually occurred, due to logistical reasons discussed below, within two months of the Anniversary Period.[41]

[40] This was the attendant's re-hire date. The attendant had previously been terminated on February 26, 2006. Payroll documentation of this termination and re-hiring are included in the sample-by-sample binders.

[41] Heritage contemporaneously completes an "In-Service Tracking Log" for each attendant to record the dates and hours of training he or she receives in a given anniversary period. Heritage's recording of trainings on this log reflects Heritage's and the attendant's intention as to which anniversary period the hours should be credited.

Sample Item No.	Anniversary Period	Training Hours[42]	Notes
15	9/4/06 to 9/3/07	12 (18)	8 hours occurred 25 days after Anniversary Period. 2 (8) hours occurred 37 days after Anniversary Period.
19	9/21/06 to 9/20/07	10 (16)	8 hours occurred 7 days before Anniversary Period. 6 hours occurred 65 days after Anniversary Period.
30	5/25/06 to 5/24/07	13 (19)	8 hours occurred 35 days before Anniversary Period.
38	2/27/07 to 2/26/08	7 (13)	3 hours occurred 7 days before Anniversary Period.
39	9/29/06 to 9/28/07	12 (18)	2 (8) hours occurred 50 days before Anniversary Period.
40	12/14/06 to 12/13/07	13 (19)	12 (18) hours occurred 34 days after Anniversary Period.
51	5/7/06 to 5/6/07	17 (23)	10 (16) hours occurred 2 to 4 days before Anniversary Period.
55	6/18/08 to 6/17/09	13 (21)	3 (9) hours occurred 12 to 14 days before Anniversary Period.
56	4/12/07 to 4/11/08	12 (18)	3 (9) hours occurred 18 days before Anniversary Period.
58	11/29/06 to 11/28/07	13 (19)	10 hours occurred 2 days after Anniversary Period.
59	2/15/07 to	3 (9)	2 (8) hours occurred 18 days before Anniversary Period.

[42] The numbers in this column in parentheses indicate the total training hours once the general competencies training, if any for the particular attendant, is properly credited as eight hours. As discussed in greater length in the affidavit of Jenni McNab, sent via overnight mail by cover dated yesterday, the general competencies training provided to Heritage's attendants should always have been credited as eight hours, not two, because of the average amount of time taken by attendants to complete this training and the diversity of topics covered, including quality improvement, universal precautions, customer service, personal safety, fire safety, body mechanics and the homemaker competency examination.

	2/14/08		
63	5/29/06 to 5/28/07	18 (24)	10 (16) hours occurred 15 to 16 days before Anniversary Period.
72	11/5/06 to 11/4/07	18 (24)	8 (14) hours occurred 34 days before Anniversary Period. 9 hours occurred 9 days after Anniversary Period.
74	8/25/07 to 8/24/08	12 (18)	12 (18) hours occurred 5 days before Anniversary Period.
91	12/11/06 to 12/10/07	12 (18)	11 (17) hours occurred 2 to 8 days before Anniversary Period.

As the OIG is aware, Heritage tracked its attendants' annual training by reference to an attendant's Anniversary Period. In doing so, Heritage ensured that its attendants had 12 hours of training within every 12-month period. The PCO regulations do not require PCO Agencies to track or require training hours by anniversary period, rather than by calendar year. Heritage's method of tracking training ensured that an attendant could not go for long spans of time without the necessary training. This should be contrasted to tracking training by calendar year, which allows an attendant to go 23 months between training sessions.

Second, as to 11 of the 29 remaining sample item numbers, the attendants also were in substantial compliance with the 12-hour training requirement in that the attendants had between nine and 12 hours of training for the applicable Anniversary Period.

Sample Item No.	Anniversary Period	Training Hours[43]
12	8/8/07 to 8/7/08	5 (11)
18	10/22/06 to 10/21/07	9 (15)
19	9/21/06 to 9/20/07	10 (16)
23	8/3/06 to 8/2/07	3 (9)

[43] The numbers in this column in parentheses indicate the total training hours once the general competencies training, if any for the particular attendant, is properly credited as eight hours.

38	2/27/07 to 2/26/08	7 (13)
39	9/29/06 to 9/28/07	11 (17)
59	2/15/07 to 2/14/08	3 (9)
60	9/12/07 to 9/11/08	4 (10)
64	3/26/07 to 3/25/08	11 (17)
65	2/19/08 to 2/18/09	4 (10)
98	5/25/06 to 5/24/07	3 (9)

Because of this substantial compliance, the above 11 sample item numbers also should not be treated as deficiencies under the PCO regulations.

This is particularly so in light of the logistical issues faced by Heritage, and likely all other PCO agencies, as to training in the home care context. First, Heritage encounters difficulty obtaining training within the confines of the technical Anniversary Period because of the commonality of attendant-family members. That is, attendants under the PCO Program are frequently family members of the client. These attendants get paid for their services provided pursuant to the applicable Personal Care Services Plan ("PCSP"), but the attendants provide many additional services to their family members as a function of being related to the client. It is not surprising, then, that a daughter with a PCO-eligible mother at home might find it difficult to attend 12 hours of training annually. Indeed, it is not uncommon for Heritage's attendants to bring their family member-client to the training in order to provide that family member-client with needed care while still meeting the training requirements. Heritage recognizes this difficulty and, when necessary, accepts training from some attendants that does not technically fall within an anniversary period, but is close in temporal-proximity to justifiably be attributed to it. A second difficulty encountered by Heritage regarding training is simply that of language barriers. Heritage endeavors to meet the needs of its diverse client pool by providing the services of attendants who can converse with their clients in the clients' preferred language. This means that Heritage is often faced with translating entire training modules and tests for specific attendants in languages from Spanish to Vietnamese.

Despite these logistical difficulties, Heritage voluntarily has undertaken several initiatives in its efforts to ensure future 100 percent compliance with the training requirements in the PCO regulations. Among these, Heritage has issued a policy requiring its scheduling and payroll

personnel supervisor and its executive director to begin auditing annual training for completion and compliance quarterly.

III. Conclusion

For the reasons set forth above, Heritage disputes the findings and recommendations contained in the Draft Report. Moreover, for the same reasons that Heritage would not and should not be subject to recoupment of Medicaid monies under New Mexico and federal law, neither should HSD be required to make the repayment recommended in the Draft Report. If you have any further questions or would like any further documentation regarding the Draft Report, please do not hesitate to contact me.

Sincerely,

BANNERMAN & JOHNSON, P.A.

David H. Johnson

- and -

ARENT FOX LLP

for

Linda A. Baumann

cc: Len Trainor

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

February 13, 2012

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 Provided by Heritage Home Healthcare, A-06-09-00063

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-06-09-00063 titled "Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare."

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
New Mexico 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-06-09-00063 on Medicaid Personal Care Services, Heritage Home Healthcare

Table of Contents

A. Introduction

In December 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 Heritage Home Healthcare" ("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 Heritage Home Healthcare ("Heritage") submitted. MAD also requested, received, and reviewed documentation from Heritage offered in support of its response to the Draft Audit.

B. Summary of Response

MAD strongly disagrees that these findings support the recommendation of the Draft Audit that the State return $4,483,492 in Federal funds received in response to the Heritage claims and paid to the provider. The Draft Audit identifies five 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 $2,243.[1] It then extrapolated this conclusion to the universe of Heritage's claims for the two-year review period, to arrive at the amount of $4,483,492 in alleged "overpayments" of Federal funds for the full universe of 363,903 Heritage claims during the audit period.

We respectfully disagree with this conclusion. Four of the five categories of "deficiencies," and 35 of the 36 alleged "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 underlying personal care services were valid, allowable, and rendered to eligible beneficiaries, notwithstanding the absence of certain documents. Moreover, for the most part, the missing documentation related not to federal requirements but to state requirements. The applicable state law does not require recovery of payments made to providers even if there was a violation of those state requirements.[2] When the State determines that violations of these requirements have occurred, the Quality Assistance Bureau ("QAB") has a policy and practice of issuing corrective action plans to prevent further violations.[3]

For the remaining category, while MAD acknowledges that the findings support a conclusion that there was a single overpayment of $12.28, they do not support extrapolating that conclusion to the universe

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[1] The Draft Audit examined only Heritage'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.

[2] The State documentation regulations in effect during the audit period required recoupment only if HSD audits "show inappropriate billing *for services*," N.M. Admin. Code § 8.315.4.11A(14) (2004) (emphasis added). The current State regulations similarly focus upon whether the *underlying services* were in fact rendered by requiring "recoupment of funds . . . when audits show inappropriate billing or inappropriate documentation *for services*." *Id.* § 8.315.4.12B(5) (2012).

[3] Nothing in this statement is intended to address situations covered by Medicaid fraud and abuse provisions.

of all claims submitted during the two-year review period. Rather than revealing a pattern of misclaiming or any systemic failure on the part of Heritage, the Draft Report identified only one instance in which unsupported units were billed. The OIG's findings concerning unsupported attendant service units are too isolated, and the sole instance in which unsupported units were found clearly is an aberration from the provider's normal practices.

Overall, the findings of the Draft Audit reveal a provider that has been highly compliant with applicable requirements. At most, the few "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. As explained in Heritage's response letter, it has already voluntarily undertaken considerable corrective actions relating to the categories of "deficiencies" to ensure future compliance with the underlying State and Federal requirements.

In addition, MAD challenges the OIG's findings concerning the specific claims selected for review because Heritage has been able to provide documentation demonstrating that it complied with the applicable laws. For the reasons detailed below, it would be unreasonable for the Federal government to require recoupment of nearly 20 percent of the Federal funds that Heritage received during the audit period for administering PCO services ($16,058,247), especially when the OIG reviewed only 100 cases or less than 0.03% of the total 363,903 claims.

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 assistance 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 C.F.R. § 440.167, New Mexico has developed PCO eligibility and service criteria. Individuals aged 21 or older who are eligible for 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 Heritage Deficiencies

The OIG's Draft Audit concluded that MAD did not always ensure that Heritage'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, 64 (totaling $3,837) were in full compliance, and 36 (totaling $2,243) were not. The auditors further determined that 1 of the 24 non-compliant claims was partially allowable. The Draft Audit identified 41 alleged deficiencies contained in those 36 claims which fall into the following 5 categories:

- Missing documentation of annual training (28 claims)
- Missing attendants' cardiopulmonary resuscitation ("CPR") and/or first aid certification (6 claims)
- Missing evidence of tuberculosis training (1 claim)
- Missing prior approval for personal care services provided by a legal guardian or attorney-in-fact (5 claims)
- Unsupported attendant service units (1 claim)

As is shown in the following paragraphs, while one of the alleged categories of deficiencies indicates that a single claim was paid that should not have been paid, all the remaining categories involved technical or documentation problems that do not support a conclusion that payments were improperly made.[4]

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

1. Missing Annual Training Documentation

Draft Audit Finding: The OIG auditors found that for 28 of the 100 sampled claims Heritage 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 $1,642.96. The Draft Audit would reject these claims in their entirety.

MAD Response: Federal law does not require attendants to undergo a specified amount of training in the 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.

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[4] The Draft Audit also identified one type of deficiency in Heritage'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 (27 claims).

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.

In all 28 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. In fact, in 5 of the cases, the attendant completed 12 or more hours of training within 2 weeks of the anniversary period, and in 15 cases, this training was completed within 2 months of the anniversary period, indicating that the attendants were in fact adequately trained, even if not within the technical bounds of the anniversary period.

Heritage has already taken corrective action to prevent future violations of the State requirement. It issued a policy requiring the scheduling and payroll personnel supervisor and its executive director to begin auditing annual training for completion and compliance each quarter.

2. Missing CPR or First Aid Certification

Draft Audit Finding: The OIG auditors determined that in 6 of the 100 sampled claims Heritage could not provide copies of the attendant's CPR or first aid certification as required by section 8.315.4.11A(2)(d) of the NMAC. The amount of the claims in question totals $418.39. The Draft Audit would reject these claim in their entirety.

MAD Response: There is no Federal requirement that an attendant be certified for CPR or first aid, 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 for the services furnished by the attendant.

In 5 of the 6 cases at issue, the attendant had both CPR and first aid certification, but this certification lapsed for a period of months and was renewed soon after. These attendants were trained in CPR and first aid and competent to provide such aid if needed. In the last case (sample 58), the attendant subsequently obtained the certification. This case is an isolated instance in which the attendant lacked CPR and first aid training when PCO services were furnished that by no means indicates that Heritage systematically failed to comply with the CPR and first aid State requirement.

Heritage has already taken corrective measures to prevent services from being provided by attendants who lack CPR or first aid certification or whose certifications have lapsed. Beginning in April 2010, Heritage instituted a policy of not scheduling for work attendants who cannot provide proof of current CPR and First Aid certifications, and is reviewing the currency of scheduled attendants' certifications on a weekly basis.

3. Missing Tuberculosis Testing Documentation

Draft Audit Finding: The OIG auditors found that for 1 of the 100 sampled claims Heritage lacked documentation showing that the attendant had received a tuberculosis ("TB") skin test or chest x-ray

and tested negative for TB, or been appropriately treated before he or she furnished services to Medicaid recipients, as required by section 8.315.4.11A(37) of the New Mexico Administrative Code ("NMAC"). The amount of the claim in question is $73.68. The Draft Audit would reject this claim in its entirety.

MAD Response: Federal law does not require attendants to maintain documentation of TB tests, x-rays, and treatment administered to attendants before they furnish services, 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, and the QAB issues corrective action plans for such violations rather than recouping payments for any services rendered by the attendants for whom TB documentation is missing. 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.

The fact that there is only a single case among the 100 sampled cases in which TB testing documentation is alleged to be missing demonstrates that Heritage uniformly requires that such testing be completed and documented. Heritage has provided TB questionnaires for the attendants in question and explained that such questionnaires are administered to attendants only if they have already tested negative for TB. Thus, Heritage likely had a copy of the attendant's negative TB test results, but simply misplaced it.

In addition, in the isolated case in which the TB test results are missing, the record demonstrates 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 tuberculosis testing requirement, even if proved, does not justify withholding that FFP.

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

Draft Audit Finding: The Draft Audit determined that for 5 of the 100 sampled claims Heritage 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 amount of the allegedly deficient claims totals $353.47. 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 the 5 cases in question, 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.

In addition, Heritage has already taken corrective action to prevent future violations. It added a question to its telephone pre-screening form for prospective attendants that queries whether they are attorneys-in-fact for the beneficiaries.

5. Unsupported Attendant Service Units

Draft Audit Finding: The OIG determined that for 1 of the sampled claims Heritage failed to provide documentation supporting the number of units claimed for attendant services. The total allegedly deficient portion of this claim is $12.28.

MAD Response: Heritage has conceded that it should not have been paid for the claim in question and has already returned the amount of the claim to HSD. MAD notes, however, that this overbilling is, at most, an isolated occurrence at Heritage and the amount of the overpayment, which billed for a single hour of PCO services, is only a miniscule percentage of the total PCO claims reviewed. The $12.28 in excess billings is less than 0.2 percent of the $6,080 in PCO claims contained in the 100 cases included in the audit review. Moreover, Heritage has already taken corrective measures by conducting an internal audit of claims for a single hour of PCO services.

6. Other PCO Matters

Draft Audit Finding: The OIG auditors found that for 27 of the sampled claims Heritage charged a total of $542 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.

MAD Response: MAD concurs that the claims for meal preparation and housekeeping services provided by an attendant living in the recipient's home did not violate 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 Heritage.

F. Response to Proposed Overpayment Recovery

After calculating that 36 claims or portions of claims derived from the sample resulted in overpayments of $2,243, the Draft Audit used "statistical software" to extrapolate the total refund due to the Federal Government to be $4,483,492 in FFP for alleged unallowable PCO service claims by Heritage 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 35 of the 36 questioned claims, which account for the total $4,714 identified as overpayments by the Draft Audit.[5] 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 (including compliance in 99% cases for securing TB testing documentation, 95% compliance for providing approval for legal guardian service delivery, and 94% for securing CPR and first aid certification) negates any conclusion of non-compliance in the few instances in which 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 Heritage. To the contrary, the OIG auditors identified only one instance of overbilling. Even if the Draft Audit's findings are correct, only $12.28 of the total of $6,080 in PCO

[5] The Draft Audit concluded that 5 of the sampled claims each had 2 types of "deficiencies": 1 claim had missing evidence of annual training and unsupported units of payment, 1 had missing evidence of annual training and prior agency approval for PCO services provided by a legal guardian or attorney-in-fact, 2 had missing evidence of annual training and CPR or first aid certification, and 1 had missing evidence of CPR or first aid certification and prior agency approval for PCO services provided by a legal guardian or attorney-in-fact. In the first instance, the Draft Audit used the larger of the "deficiency" amounts (entirety of the claim for missing prior physician authorization form) in calculating the total Federal share of the 36 "deficient" claims.

claims reviewed in the audit represented amounts claims in excess of the time reflected on the timesheets or that was authorized by the service plan. This would mean that Heritage's error rate is only 0.2 percent, far less 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.

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 a high level of compliance by Heritage. 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 Heritage's PCO services. The State would be prepared to repay $8.83,[6] the federal share associated with the sole instance of overbilling.

[6] This amount was calculated by applying the FMAP rate for Federal Fiscal Year 2007 of 71.93 percent to the sample case overpayment of $12.28.

Appendix: State Policy Changes and Compliance Measures

1. Overall PCO Improvements

(a) Regulation Changes

In the last year and a half, 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 are measurable and can be included as a metric, have facial validity, 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 Heritage Deficiencies

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

(a) 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 Adult and Long-Term Services Division ("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.

(b) 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.

(c) TB Testing

Beginning in 2009, the training required of new PCO providers has emphasized the importance of compliance with the requirement for TB testing. Effective December 2010, MAD's revised PCO regulations clarified the requirement to follow the current recommendations of the New Mexico Department of Health ("NM DOH") and the Federal Centers for Disease Control ("CDC"). Technical assistance documents provided at the trainings were posted on the ALTSD and MAD websites to further reinforce this regulatory requirement and provide guidance on the process, including the required form and contact information for the NMDOH TB program. MAD also emails updates on PCO compliance issues to all PCO providers. These emails are cc'd to designated MCO staff and to the Executive Director of the New Mexico Association for Home and Hospice Care ("NMAHHC"), who then forwards the updates to PCO agencies through regular email blasts to NMAHHC members.

As detailed above in the discussion of corrective strategies relating to the annual training requirement, each of the CoLTS MCOs provides PCO agencies with continuing education regarding the State regulatory requirements and responsibilities. The State is developing a training plan for PCO providers that will include increased State oversight of the training and materials provided by the MCOs. 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 requirement to maintain documentation of compliance with the requirement for TB testing of each attendant.

(d) 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.

(e) 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 the 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.

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.

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.