Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Office of Inspector General

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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 individuals with intellectual disabilities, 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/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, Coordinated Home Health (Coordinated), a personal care services provider in Las Cruces, New Mexico, received $37,676,105 ($26,931,344 Federal share).

OBJECTIVE

Our objective was to determine whether the State agency ensured that Coordinated'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 Coordinated's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 claims in our sample,

54 (totaling $6,939) complied with requirements, but 46 (totaling $8,140) did not. Three of the forty-six claims were partially allowable. The allowable portion of the three claims was $406. The 46 claims contained a total of 60 deficiencies: 49 deficiencies on insufficient attendant qualifications and 11 deficiencies on other issues. As a result, Coordinated improperly claimed $7,734 for the 46 claims.

Based on our sample results, we estimated that Coordinated improperly claimed at least $10,962,174 (Federal share) for personal care services during the period October 1, 2006, to September 30, 2008.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $10,962,174 paid to Coordinated for unallowable personal care services and

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

COORDINATED COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Coordinated disagreed with almost all of our findings. Coordinated's comments are included in their entirety as Appendix D. Along with its comments, Coordinated provided documentation that it did not provide during our review. After reviewing the new documentation, we reevaluated some claims and determined that 13 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. The State agency said that five of the six categories of deficiencies (i.e., cardiopulmonary resuscitation (CPR) and first aid certifications, annual training, tuberculosis testing, supervisory visits, and physician authorization) did not justify withholding Federal funds because the findings did not support that payments were improperly made. The State agency also said that the documentation requirements for four of the six categories (i.e., CPR and first aid certifications, annual training, tuberculosis testing, and supervisory visits) are not Federal requirements; they are State requirements, which do not require recovery of payments.

The State agency acknowledged that for the two claims in the remaining category (i.e., unsupported units of payment), there was a single overpayment for one claim. The State agency added, however, that the overpayment was an isolated occurrence and did not support extrapolating to the universe 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 said that the other claim was simply missing a timesheet and that there was no evidence that services were not provided.

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. Regarding the State agency's assertion that requirements for four of the six categories of deficiencies are non-Federal requirements, three (i.e., CPR and first aid certifications, annual training, and tuberculosis testing) are based on Federal law and regulations, which require personal care attendants to be qualified. Further, requirements for supervisory visits are integral to the contract between the State and the personal care services agency, which directly affects how the State provides personal care services to its beneficiaries.

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.

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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 (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 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 individuals with intellectual disabilities,[1] 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.

[1] Changes in terminology are based on Rosa's Law (P.L. No. 111-256). For more information, see CMS Final Rule, 77 Fed. Reg. 29002, 29021, and 29028 (May 16, 2012).

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, 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 their compliance with Federal and State requirements. NMAC section 8.315.4.11A(21) requires the State agency to review a written justification for, and issue an approval (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, Coordinated Home Health (Coordinated), a personal care services provider in New Mexico, received $37,676,105 ($26,931,344 Federal share).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

This audit covered the $37,676,105 the State agency paid to Coordinated for 277,724 claim lines (hereafter referred to as "claims") paid 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 Coordinated's procedures for maintaining documentation related to attendants and recipients.

We conducted our fieldwork at the State agency office in Santa Fe, New Mexico; the third-party assessor's office in Albuquerque, New Mexico; Coordinated's headquarters in Las Cruces, New Mexico; and 11 other Coordinated offices in southern 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 claim 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 Coordinated to review based on payments for personal care services claims it received totaling $37,676,105 for the audit period;
- selected a random sample of 100 Coordinated claims (Appendix A);
- met with Coordinated officials to gain an understanding of Coordinated's policies and procedures and of documentation in Coordinated's recipient and attendant personnel files;
- obtained recipient documentation from the third-party assessor and Coordinated for each sampled item;
- identified the attendant(s) included in each sampled item and obtained documentation Coordinated 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 sampled item to determine whether it complied with Federal and State Medicaid requirements;

- discussed the results of our audit with officials from CMS, the State agency, and Coordinated;

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

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

- estimated the unallowable Federal Medicaid reimbursement paid for the 277,724 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 Coordinated's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 sampled items, 54 claims (totaling $6,939) complied with requirements, but 46 (totaling $8,140) did not. Three of the forty-six claims were partially allowable. The allowable portion of the three claims was $406. The 46 claims contained a total of 60 deficiencies: 49 deficiencies on insufficient attendant qualifications and 11 deficiencies on other issues. As a result, Coordinated improperly claimed $7,734 for the 46 sampled items.

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

Based on our sample results, we estimated that Coordinated improperly claimed at least $10,962,174 (Federal share) for personal care services during the period October 1, 2006, through September 30, 2008.

ATTENDANT QUALIFICATION DEFICIENCIES

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.[2] For 20 of the 100 sampled items, Coordinated did not provide evidence that the attendant was certified in CPR and/or first aid on the dates of service.

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

Annual Training

NMAC section 8.315.4.11A(2) requires provider agencies to provide all attendants a minimum of 12 hours of training per year; section 8.315.4.11A(33) requires provider agencies to maintain in attendants' files copies of documentation that all training had been completed. For 20 of the 100 sampled items, Coordinated did not provide evidence that the attendants had completed 12 hours of annual training for the calendar year of 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 9 of the 100 sampled items, Coordinated could not provide evidence that the attendants had received a TB skin test or chest x-ray or that the attendants had tested negative for TB or had been appropriately treated before the dates of service.

OTHER DEFICIENCIES

Supervisory Visits

NMAC section 8.315.4.11A(31) requires attendant supervisors to meet with recipients and/or their personal representatives in the recipients' homes at least once a month. For 8 of the 100 sampled items, Coordinated did not provide evidence that the attendants' supervisors had made the required visits.

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 2 of the 100 sampled items, Coordinated did not have evidence to support the amount of units claimed for attendant services. Specifically, for one claim, there was no timesheet; for the second claim, the number of units on the timesheet was less than the number of units claimed.

Physician Authorization

Federal regulations (42 CFR § 440.167) require personal care services to be authorized by a physician pursuant to a plan of treatment or, at the State agency's option, otherwise authorized in accordance with a service plan approved by the State. In addition, NMAC requires third-party assessors or their designees to maintain for each recipient evidence of a physician authorization form signed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (section 8.315.4.16A). For 1 of the 100 sampled items, Coordinated did not provide documentation of a physician authorization.

EFFECT OF DEFICIENCIES

Based on our sample, we estimated that Coordinated improperly claimed at least $10,962,174 (Federal share) for personal care services.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $10,962,174 paid to Coordinated for unallowable personal care services and

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

COORDINATED COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

Along with its comments, Coordinated provided documentation that it did not provide during our review. After reviewing the documentation, we reevaluated some claims and determined that 13 complied with Federal and State regulations.[3] We revised the findings and recommendations accordingly.

Tuberculosis Testing

Coordinated Comments

Coordinated stated that New Mexico regulations pertaining to TB testing were ambiguous and that it had obtained a letter from the New Mexico Department of Health (DOH) indicating that TB testing was no longer required for personal care attendants. The letter, which was written by the New Mexico Public Education Department, stated that "[a]s of July 30, 2004, TB testing is no longer a requirement for employment in health facilities, schools and day care centers." Further, Coordinated stated that DOH historically had asserted authority over TB testing of health facility employees, including personal care attendants, and had repealed its health facility personnel TB testing requirement effective July 30, 2004.

Nonetheless, Coordinated stated that it had documentation of negative TB test results obtained (1) before the dates of service for most of the sampled items and (2) after the dates of service for some claims. Coordinated said that credit should be given for those claims in which the

[3] 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.

attendants had subsequently obtained TB tests because the test confirmed that the attendants were free of transmissible TB on the dates of service.

Office of Inspector General Response

Coordinated provided us a copy of the July 21, 2004, New Mexico Public Education Department letter during our fieldwork. We forwarded the letter to the State agency, which responded that the letter did not apply to personal care services and that TB testing was still required. We removed the deficiencies from the report that were related to negative TB test results obtained before the dates of service on our sampled items. However, for the remaining deficiencies, we did not accept Coordinated's assertion that TB tests performed after the dates of service should be allowable. In accordance with NMAC section 8.315.4.11A(37), we counted a sampled item as deficient if Coordinated could not provide medical documentation showing that the attendant tested negative for TB before the dates of service.

Annual Training

Coordinated Comments

Coordinated stated that we improperly applied a "calendar" year standard in our review of the annual training requirement and that the personal care regulations did not specify which 12-month period constituted a "year." Coordinated stated that it based annual training on the attendant's "employment anniversary year" and that we should have done the same.

Coordinated stated that it was led to believe that we did not credit training hours related to CPR and first aid courses and that we disallowed at least one claim because the attendant's annual training records did not include evidence of a test.

Coordinated also said that it can document substantial compliance with State training requirements for all 100 sampled items because a shortage of 1 to 3 hours of training for no more than 10 percent of sampled caregivers is an insufficient basis for concluding noncompliance.

Office of Inspector General Response

There is no Federal or State requirement that defines what constitutes a year. Therefore, we relied on the Coordinated policy manual that was in effect for the audit period, which stated that "[t]raining hours are calculated from January to December of each year."

We counted training hours for CPR and first aid courses towards the 12-hour annual requirement when those courses were taken in the calendar year of the dates of service. We did not disallow training hours based on the lack of a test; we accepted training rosters and other appropriate documentation.

We removed some of the deficiencies noted in the report based on additional documentation Coordinated provided that documented 12 hours of training within the calendar year of the dates of service. However, we cannot accept Coordinated's assertion of substantial compliance as a substitute for missing annual training hours and maintain that our remaining findings are correct.

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.

Cardiopulmonary Resuscitation and First Aid Certifications

Coordinated Comments

Coordinated stated that it had documentation for CPR and first aid certifications for almost all of the sampled items and thus was in substantial compliance with the requirement. For several of these claims, Coordinated stated that it was in substantial compliance because the attendant was out of compliance with the requirement for fewer than 3 months. Coordinated noted that for the remaining claims, the absence of documented certifications more likely reflects a recordkeeping error, not that the attendant was without the required life-saving skills.

Office of Inspector General Response

Coordinated provided some additional documentation for CPR and first aid certifications that met the requirements, and we reduced the deficiencies noted in the report accordingly. We cannot accept Coordinated's assertion of substantial compliance as a substitute for missing CPR and/or first aid certifications and maintain that our remaining findings are correct. 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. For the claims Coordinated attributed to recordkeeping errors, we cannot conclude that the attendants had the required skills without certifications.

Supervisory Visits

Coordinated Comments

Coordinated stated that it had documentation of monthly supervisory visits for almost all of the sampled items and thus was in substantial compliance with the requirement. For a few other claims, Coordinated stated that it was in substantial compliance because either multiple attempts at visits had been made during the month of the sampled item or 12 visits had been made during the year, but one had not been made during the month of the sampled item.

Office of Inspector General Response

Coordinated provided additional documentation of a supervisory visit that met the requirement, and we reduced the number of deficiencies accordingly. We cannot accept Coordinated's assertion that multiple attempts at visits during the month of the sampled item or 12 supervisory visits made during the year are an adequate substitute for conducting an actual supervisory visit during the month of the dates of service and maintain that our remaining findings are correct. NMAC section 8.315.4.11A(31) requires attendant supervisors to meet with recipients and/or

their personal representatives in the recipients' homes at least once a month. Documentation of unsuccessful attempts at supervisory visits does not meet the supervisory visitation requirements.

Physician Authorization, In-Home Assessment, and Personal Care Services Plan

Coordinated Comments

Coordinated said that we were incorrect to cite it for deficiencies related to physician authorizations and in-home assessments. Coordinated stated that it had PCSP documentation for all sampled items and that the regulations do not require the provider agencies to obtain and maintain copies of physician authorizations and in-home assessments.

Office of Inspector General Response

Coordinated provided us with the physician authorization, in-home assessment, and PCSP for one claim that was missing these three documents, and we reduced the number of deficiencies accordingly. However, one claim was still missing a physician authorization for the applicable PCSP. We reviewed files at both the third-party assessor and Coordinated and could not locate the applicable physician authorization. Although we agree that State regulations place the responsibility of maintaining the physician authorization with the third-party assessor, Federal and State regulations (42 CFR § 440.167 and NMAC section 8.315.4.16A, respectively) require that, for personal care services to be reimbursable, a physician authorization is required.

Unsupported Units Claimed

Coordinated agreed with our finding.

Imperfect Compliance

Coordinated Comments

Coordinated stated that New Mexico law does not require compliance with NMAC section 8.315.4 as a condition of payment for personal care services. Rather, NMAC section 8.315.4 details the conditions for provider participation in the personal care services program. Coordinated also said that the State agency does not use recoupment of payments as an enforcement tool in policing providers in the Medicaid program.

Office of Inspector General Response

To provide a valid and payable service, personal care services providers 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

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.

Sampling Methodology

Coordinated Comments

Coordinated stated that extrapolating our audit findings for the 100 sampled items to the population of all 277,724 personal care claims that Coordinated submitted to Medicaid for the period October 1, 2006, to September 30, 2008, is inconsistent with New Mexico auditing standards. Specifically, New Mexico's Medicaid program has a long history of not extrapolating the findings of audits that it conducts to a larger universe of claims. Coordinated said that New Mexico's Medicaid program has had a policy of recouping funds on a line-by-line basis.

Coordinated said that it had identified a decimal point error in the "LINE_PC_UNITS"[4] for at least 27 of the sampled items. Coordinated said, for example, that the units corresponding to claim 31 should be 68, not 6.8. Coordinated said that, as a result, these decimal point errors call into question the accuracy of the data from which we drew our sample and the accuracy of our extrapolated findings. Coordinated said that it believes that we should have discovered these errors during our data validation process.

Office of Inspector General Response

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. Accordingly, we are not required to determine whether our extrapolation of errors identified in our audit is consistent with New Mexico's standards.

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.[5] 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."[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 a valid type of collection for extrapolation purposes.[8]

[4]The "LINE_PC_UNITS" Coordinated refers to are the "LINE_PD_UNITS." These units refer to the time charged on the claim.

[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 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).

[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).

Further, such statistical sampling and such a methodology may be used in cases seeking recovery against States and individual providers or private institutions alike.[9]

The Departmental Appeals Board (DAB) has stated that using statistical sampling to estimate the amount of overpayment is more reasonable, practicable, and cost-effective than claim-by-claim review when a "magnitude" of disputed claims exists. See, e.g., *Tennessee Department of Health and Environment*, DAB 898 (1987), and *Ohio Department of Public Welfare*, DAB 226 (1981).

We did not use the "LINE_PC_UNITS" field or any of the other numeric fields (unit counts or dollar amounts) from the claims data provided by the State agency to draw our sample. Nor did we use any of the numeric fields from the State agency's claims data to extrapolate our findings. We used only the claim and line numbers from the State agency claims data when creating our sampling frame. We used the number units shown in Coordinated's supporting documentation for each claim line and the unit rate for personal care (established by the State agency) to arrive at the actual payment amount for the 100 sampled items. After evaluating the service on a claim to determine the allowable payment amount, we used the total number of unique sampled items derived from the claims data provided by the State agency to estimate the unallowable personal care services payments.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In its written comments on our draft report, the State agency disagreed with our recommended refund amount.

The State agency said that five of the six categories of deficiencies (i.e., CPR and first aid certifications, annual training, tuberculosis testing, supervisory visits, and physician authorization) did not justify withholding Federal funds because the findings did not support that payments were improperly made. The State agency also said that the documentation requirements for four of the six categories (i.e., CPR and first aid certifications, annual training, tuberculosis testing, and supervisory visits) are not Federal requirements; they are State requirements, which do not require recovery of payments.

The State agency agreed that for the two claims in the remaining category (i.e., unsupported units of payment), there was a single overpayment for one claim but stated that this deficiency was an isolated occurrence and did not support extrapolating the overpayment to all claims submitted during the 2-year review period. The State agency said that the overpayment was only 0.05 percent of all claims reviewed in the audit, far less than the tolerance limits established in certain Federal programs. [10] The State agency added that in these programs, standard Federal

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

[10] 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).

policy in such circumstances is to seek recovery only for the overpayments identified and not to extrapolate the results. The State agency said that the other claim was missing a timesheet and that there was no evidence that services were not provided. The State agency said that the timesheet was most likely misplaced.

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

Office of Inspector General Response

The deficiencies cited in the report, i.e., supervisory visits, CPR and first aid certification, annual training, tuberculosis testing, supervisory visits, unsupported units of payment, and physician authorization, are based on significant service-related requirements. Taken as a whole, these deficiencies are too numerous to be dismissed as just a few missing files, particularly when the deficiencies in question are related to quality of care.

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

We disagree with the State agency regarding the missing documentation of supervisory visits. The State requires that personal care services agencies enter into a contract to provide the services listed under NMAC 8.315.4.11. This regulation is a key provision governing how the State provides personal care services under its State plan. The regulation contains a broad array of requirements that specifically control the delivery of the personal care services benefit; supervisory visits are one of those requirements. Without evidence of the required supervisory visits, Coordinated did not satisfy the terms of its contract. Thus, we have retained the deficiencies for missing documentation of supervisory visits.

The methodology we used to select the sample and evaluate the results of that sample has resulted in an unbiased estimate (extrapolation) of the value of Coordinated's unallowable personal care services. As stated in New York State Department of Social Services, DAB 1358 (1992), "… sampling (and extrapolation from a sample) done in accordance with scientifically accepted rules and conventions has a high degree of probability of being close to the finding which would have resulted from individual consideration of numerous cost items and, indeed, may be even more accurate, since clerical and other errors can reduce the accuracy of a 100% review."

The Coordinated 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." We explain the validity of the use of sampling and extrapolation as part of audits in connection with Federal health programs and the courts' approval of the use of those methods on page 10.

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.

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

OTHER MATTER

MEAL PREPARATION AND HOUSEKEEPING SERVICES PAID FOR RECIPIENTS LIVING WITH ATTENDANTS

In reviewing supporting documentation for 30 of the 100 sampled items, we found that $1,829 was charged 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 Coordinated Home Health (Coordinated) 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 one unit of service).

SAMPLING FRAME

The sampling frame consisted of 277,724 personal care services claim lines (totaling $37,676,105) 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 Coordinated.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

We used the 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 277,724. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the 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)
277,724	$26,931,344	100	$10,773	46	$5,536

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

Point estimate	$15,374,578
Lower limit	$10,962,174
Upper limit	$19,786,983

APPENDIX C: REASONS FOR DEFICIENT CLAIM LINES

1	Missing Evidence of Cardiopulmonary Resuscitation and/or First Aid Certifications
2	Missing Evidence of Annual Training
3	Missing Evidence of Tuberculosis Testing
4	Missing Evidence of Supervisory Visits
5	Unsupported Units of Payment
6	Missing Evidence of Physician Authorization

No.	1	2	3	4	5	6	No. of Deficiencies	Sample Item No.[1]
1			X				1	1
2	X						1	2
3	X	X					2	4
4		X					1	7
5	X	X		X			3	8
6	X						1	10
7	X						1	16
8		X					1	18
9	X						1	20
10		X					1	21
11	X		X			X	3	23
12		X					1	25
13		X					1	27
14	X						1	28
15	X		X				2	29
16		X					1	30
17		X					1	31
18				X			1	34
19		X					1	36
20			X	X			2	40
21				X			1	41
22		X					1	45
23	X						1	46
24				X			1	48
25	X						1	54
26					X		1	56
27		X					1	58
28	X						1	59
29			X				1	62

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

No.	1	2	3	4	5	6	No. of Deficiencies	Sample Item No.[1]
30			X				1	63
31		X					1	65
32		X					1	66
33	X						1	76
34		X	X				2	78
35					X		1	79
36			X				1	80
37	X	X					2	81
38		X					1	85
39	X						1	86
40		X					1	88
41	X						1	90
42	X			X			2	91
43		X		X			2	94
44	X		X	X			3	96
45	X	X					2	97
46	X						1	99
Total	20	20	9	8	2	1	60	

Total deficiencies for “Attendant Qualification Deficiencies” (columns 1 through 3) is 49.
The total for “Other Deficiencies” (columns 4 through 6) is 11.

APPENDIX D: COORDINATED COMMENTS

Coordinated Home Health

Caring Since 1984

September 7, 2010

VIA OVERNIGHT DELIVERY AND ELECTRONIC MAIL

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

Re: Draft Report Number A-06-09-00064

Dear Ms. Wheeler:

Coordinated Home Health Care, Inc. ("Coordinated") appreciates being offered the opportunity to provide a written response to the draft audit report prepared by the Department of Health and Human Services' Office of Inspector General ("OIG"), entitled *Review of New Mexico Medicaid Personal Care Services Provided by Coordinated Home Health* ("Draft Report") which examined services furnished under the New Mexico Personal Care Option Program ("PCO Program"). Our response is divided into four (4) sections. Specifically:

- Section I of this letter provides a brief overview of Coordinated and the quality services it has provided to individuals within New Mexico since 1984.
- Section II rebuts the individual issues that OIG addressed in the Draft Report by explaining how OIG may have misinterpreted the requirements imposed on PCO providers by the New Mexico Human Services Department ("HSD") and/or may not have reviewed the complete set of relevant documentation. There are 7 categories of issues addressed: (1) Tuberculosis ("TB") testing; (2) annual training; (3) CPR/ first aid certification; (4) criminal background checks; (5) supervisory visits, (6) physician authorization, in-home assessment, and Personal Care Service Plans ("PCSP"); and (7) unsupported units claims.
- Section III sets forth the legal arguments to support our conclusion that many of the issues identified by OIG should not serve as a basis for recoupment of payment for claims submitted.
- Section IV describes how OIG's extrapolation from its sample to a global amount for the entire time period is otherwise flawed.

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I. OVERVIEW OF COORDINATED

Coordinated has been providing quality care to New Mexico residents since 1984. Coordinated provides personal care needs to clients who are unable to perform activities of daily living because of a disability or a functional limitation. The company currently serves approximately 1,000 clients and provides jobs for 1,000 caregivers. The care provided allows our clients to live in their homes and communities among family members and friends. The delivery of care in the home setting allows our clients to avoid institutionalization, while maintaining or increasing our clients' functional levels and independence. The services Coordinated provides to our clients include bathing, dressing, grooming, eating, toileting, caring for assistance animals, cognitive assistance and communicating. Many of these individuals have no one else to help them.

Over the last several months, Coordinated has experienced a number of changes that have helped to enhance the company's policies and procedures. The first change experienced by Coordinated was my appointment in January 2010 as Coordinated's new President. I have over twenty years of executive experience in the health care industry, including 15 years in the New Mexico home health sector. I have served as the president of the New Mexico Association for Home and Hospice Care and will once again be serving in that position in 2012.

Since my arrival at Coordinated, we have centralized a number of functions which I strongly believe will help us achieve greater ongoing program compliance. For example, Coordinated has:

- Centralized all recordkeeping with respect to caregiver and client files in the Las Cruces corporate office, namely for quality and control purposes. Files are no longer stored in individual regional offices. The Human Resources Manager is responsible for caregiver file maintenance and the Compliance Manager is responsible for client file maintenance. In order to ensure compliance with State and Federal regulations, internal audits of caregiver and client files are conducted by corporate personnel on an ongoing basis.

- Client authorizations are now centrally managed and tracked by the Authorization Coordinator in the corporate office. This ensures that the required care plan documentation for each client is in place prior to placing a caregiver in the client's home.

- In-home visits are now tracked on a weekly basis by the Compliance Manager. This ensures that clients who are hospitalized and/or out of town are tracked more closely, allowing the company to meet client needs while remaining compliant with State and Federal regulations.

Additionally, the Allscripts® software system[1] is a fairly new addition to Coordinated, as it was not fully implemented in all locations until the middle of 2008, subsequent to the audit period. Prior to that time, the company relied on different software packages and manual systems that were meant to track various items but which did not work congruently. Some of the enhancements to systems and procedures resulting from the Allscripts® implementation are:

- Subsequent to receiving the findings in the OIG Draft Report, Coordinated modified its Allscipts® application to function as the primary tool to monitor compliance with PCO regulations, and the company no longer relies on manual controls enforced by branch managers at each location. The software will not allow caregivers to be scheduled for work unless all of the compliance fields reflect a current date. The compliance fields track TB testing, attendant training, CPR and first aid certifications, and criminal background checks. A caregiver who is denied for scheduling must take appropriate action to come into compliance with the required standard(s) before s/he will be scheduled for work. In addition, Coordinated continues to implement available Allscripts® functionality to further improve controls and compliance.

- Client schedules are prepared in Allscipts® based on the centrally managed authorizations. Hours that are not authorized cannot be scheduled, and thus cannot be worked or billed. Allscripts® regulates the time frame and the number of hours worked.

- The use of Allscripts® ensures accurate billing of personal care services, as caregiver's start and finish times from timecards are entered into Allscripts® and the software calculates the number of hours worked. As a result, Coordinated no longer relies upon manual calculation of caregiver hours.

- Allscripts® allows for Coordinated to automatically generate weekly exception reports for any scheduled shifts not supported by a timecard. This process better facilitates prompt submission of timecards and ensures that shifts are not billed to the New Mexico Medicaid payee until a corresponding timecard is received and on file.

Coordinated is also evaluating software so that all caregiver and client records can be scanned for electronic use and storage.

II. COORDINATED'S RESPONSE TO OIG'S FINDINGS FOR THE SAMPLED CLAIMS

OIG concluded in its Draft Report that only 41 of 100 sample claims for Medicaid personal care services complied with certain State requirements and that there were potential issues with 59 of the 100 sample claims. Set forth below is a discussion of each of the seven categories of issues identified in the Draft Report, the reasons we believe that OIG

[1] Allscripts® is an industry leading software system that performs billing, scheduling and administrative tasks. Allscripts® is designed to employ best practices for quality control and compliance.

misinterpreted certain State law requirements applicable to PCO providers, and how review of a more complete set of relevant documentation confirms that the requirements were substantially complied with for these claims.

A. TB Testing

In its review of personal care service attendant qualifications, OIG audited records of attendant TB testing, claiming that "NMAC section 8.315.4.11(A)(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."[2] Based upon this review, OIG claimed that for 29 of the 100 sampled claims Coordinated could not provide evidence that the attendants had received a TB skin test or chest x-ray or that the attendants had tested negative for TB or been appropriately treated before the dates of service.

However, as set forth in greater detail below, Coordinated received guidance from the State dating back to 2004, stating that TB testing would no longer be required for health facility workers as a condition of employment. Records maintained by Coordinated evidence that management, at the time, reasonably relied upon these representations by New Mexico's government officials in revising its company policy as to TB testing. Nonetheless, Coordinated can provide documentation showing that the attendants who provided care for 99 out of the 100 sampled claims were TB negative on the sample dates of service.

1. Ambiguity in the New Mexico Regulations pertaining to TB testing coupled with communications from State officials led Coordinated to understand that TB testing was no longer required for PCO attendants.

For purposes of background, there are several governmental agencies in New Mexico that oversee portions of the PCO Program: the New Mexico Human Services Department (in which New Mexico Medicaid is a division (specifically the Medical Assistance Division ("MAD")), the Department of Health ("DOH") and the Aging and Long-Term Services Department. Although the current HSD regulations may include a provision within the PCO Program regulations that addresses TB testing of personal care attendants, DOH is the agency that has historically asserted authority over TB testing of health facility employees (including PCO attendants). In fact, DOH has a long record of overseeing TB control among health facility personnel. DOH's regulations pertaining to "control of communicable disease in health facility personnel" date back at least to December 1979, when the regulations were promulgated under HED 81-7.[3] The regulation in its modern iteration was adopted into section 7.4.4 of the first version of the New Mexico Administrative Code ("NMAC"), effective October 31, 1996. NMAC § 7.4.4 required that:

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[2] Department of Health and Human Services, Office of Inspector General, REVIEW OF NEW MEXICO MEDICAID PERSONAL CARE SERVICES PROVIDED BY COORDINATED HOME HEALTH NO. A-06-09-00064, 4 (Draft, July 2010) (hereinafter "Draft Report").

[3] *See* N.M. ADMIN. CODE § 7.4.4 (2004) (*repealed* July 30, 2004); 7 N.M. Reg. 571 (Aug. 31, 1996) for the regulatory history of NMAC § 7.4.4.

> A person on first employment in a New Mexico health facility and after exposure to an active case of infectious tuberculosis, shall obtain and retain a certificate stating that s/he is free from tuberculosis in a transmissible form. An operator of a health facility shall also obtain such certification.[4]

Pursuant to the DOH regulation, an employee's health certificate was required to show the results of an intradermal TB test or chest x-ray.[5] As chief enforcer of the DOH TB testing requirement, the Public Health Division not only assessed health facility compliance with the regulation but also made pre-employment testing available to individuals through local public health offices.

NMAC § 7.4.4 further specified that the DOH regulation governed all "people employed or who are seeking employment or who volunteer in health facilities or child care centers in New Mexico," and was promulgated "to ensure the health and safety of individuals by preventing exposure to tuberculosis in a transmissible form while working, attending or otherwise being located in a health facility or child care center."[6] With a broad definition of "health facility," the DOH regulation applied to providers of personal care services, such as Coordinated. Therefore, from its inception in 1984, Coordinated followed DOH guidelines by requiring that all caregivers, as a condition of employment:

> Provide a copy of a valid TB test with negative results prior to being scheduled for a client shift, and continue to update TB test or chest X-rays as required. (Known reactors must present a copy of an x-ray with negative results or certification that drug therapy has been completed, to validate that the person is free from communicable disease.)[7]

However, effective July 30, 2004, DOH repealed NMAC § 7.4.4, thereby ending its health facility personnel TB testing requirement. Notice of the repeal was published twice in the New Mexico Register, first in conjunction with notice of a June 28, 2004 public hearing on the repeal, and then as final notice of the effective date of repeal.[8]

While DOH appears not to have publicly issued guidance on the effect of the repeal, DOH did advise Coordinated and prospective employees following the repeal that TB testing of employees was no longer required by the State. On multiple occasions, DOH officials provided Coordinated employees with copies of a letter issued by Gloria Glasgow of the state of New Mexico Public Education Department ("Glasgow Letter") stating that, "[a]s of July 30, 2004, TB

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[4] N.M. ADMIN. CODE § 7.4.4(8.1) (2004) (*repealed* July 30, 2004) (enclosed as **Attachment 1**).
[5] N.M. ADMIN. CODE § 7.4.4(8.7) (2004) (*repealed* July 30, 2004).
[6] N.M. ADMIN. CODE §§ 7.4.4(2.1), (6) (2004) (*repealed* July 30, 2004).
[7] Coordinated Care Corp., *Caregiver Conditions of Employment, in* SUPPLEMENT TO EMPLOYEE HANDBOOK – CAREGIVER, 2 (Rev. Aug. 2003) (enclosed as **Attachment 2**).
[8] *See* 15 N.M. Reg. 335 (May 28, 2004) (enclosed as **Attachment 3**); 15 N.M. Reg. 765 (July 30, 2004) (enclosed as **Attachment 4**).

testing is no longer a state mandated requirement for employment in health facilities, schools and day care centers."[9] The letter is dated July 21, 2004 and although it contains no citation to the provision that was repealed, the letter otherwise identifies NMAC § 7.4.4 as the applicable regulation through reference to the June 28, 2004 public hearing and the following summary: "[the repealed regulation] requires persons employed or who are seeking employment or who volunteer in health facilities and day care centers to be tested and maintain certification that they are free from Tuberculosis (TB) in a transmissible form." The letter justifies the repeal on the basis of recommendations from the American Thoracic Society in conjunction with the CDC that states discontinue mandated and mass pre-employment TB screening and require testing only of individuals at high risk for TB. "Screening low-risk individuals" the letter states, "often results in false positive tests and subsequent unnecessary treatment, diverting financial and human resources from other priority activities."

Coordinated has documentation that the Glasgow Letter was provided to Coordinated by DOH on several occasions[10] and that State officials discussed with Coordinated the repeal of the DOH TB testing mandate.[11] Relying upon these communications and representations from DOH that the agency had discontinued its employee TB testing mandate, Coordinated changed its policy to no longer require TB testing of employees. Coordinated's decision is documented in an October 1, 2004 memo from Coordinated's former owner to all Coordinated supervisors.[12] The memo discusses how Coordinated had received numerous copies of the Glasgow Letter from caregivers who were provided the letter by DOH when the Department declined to administer a TB test to the caregivers. The memo also alludes to Mrs. Roberts' communications with DOH in stating that, "[w]e have been told this position is going to be uniform except for highly exposed areas such as in-patient care." Mrs. Roberts' memo concludes: "Due to this, effective immediately we are no longer going to require TB tests for our caregivers."

HSD itself appears to have acted in reliance upon DOH's repeal of the health facility testing requirement. Indeed, HSD deferred to DOH on matters of TB control well before the repeal of NMAC § 7.4.4. Almost from the outset of the PCO program, HSD synchronized its TB testing requirements to conform with DOH regulations, as evidenced by this provision from the

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[9] Letter from Georgia Glasgow, Health and Nursing Services Consultant, New Mexico Public Education Department, School Health Unit, to Superintendents, Principals and School Nurses (July 21, 2004).

[10] A copy of the letter appears to have been provided by the Hidalgo County Public Health Department to a prospective Coordinated employee on July 26, 2004 (four days prior to the official repeal of NMAC § 7.4.4), who then shared the letter with Coordinated (enclosed as **Attachment 5**). Further evidencing that prospective Coordinated employees were being given the letter in late July 2004 is a fax cover letter from a Coordinated employee to Coordinated's Quality Assurance Manager (enclosed as **Attachment 6**). *See also,* **Attachments 7-8**.

[11] A copy of the Glasgow Letter received by Coordinated on July 26, 2004 (enclosed as **Attachment 5**) contains a handwritten note initialed by Lila Roberts (former owner of Coordinated) reflecting that she had a telephone conversation with Georgia Glasgow the signatory of the PED letter on July 28, 2004. In addition, Mrs. Roberts November 2004 calendar (enclosed as **Attachment 9**) reflects a November 23 appointment with Dr. Ron Voorhees (then Chief Medical Officer of DOH) "per TB new law" and a November 30 appointment with Steve Dossey (then Deputy Director of DOH's Division of Health Improvement) "re TB will e-m[ail] or fax."

[12] Memorandum from Mrs. Roberts to All Supervisors regarding TB tests (Oct. 1, 2004) (enclosed as **Attachment 10**).

2002 Medicaid Personal Care Service Standards ("Standards"): "[t]he Personal Care Attendant must have a current tuberculosis (TB) skin test or chest x-ray upon initial employment with the provider agency per the current standards of the Department of Health."[13]

HSD modified its approach when it updated the PCO regulations in 2004 to incorporate the Service Standards issued in 2002.[14] This time, instead of adopting DOH's TB testing standard by reference, HSD inserted into its regulation language from DOH's rule.[15] At the same time, the 2004 HSD regulation reinforced the nexus between HSD and DOH with regard to attendant TB testing by providing that "TB testing must be conducted thereafter, pursuant to the current standards of the department of health."[16] In addition, HSD did not define many of the terms of art in its TB regulation (such as what the agency intends by "upon initial employment") and also did not include certain details, such as the parameters for determining when a TB test is negative (i.e. maximum size of induration). This further reinforces HSD's reliance upon DOH for guidance and clarification.

HSD finalized its amendments to the PCO regulations within a month of DOH repealing its own rule; however, it is unlikely that HSD intended to break with DOH policy. The PCO regulation amendments that included the TB provision were proposed by HSD prior to any notice from DOH that it was considering repeal of its TB testing regulation. HSD published notice of the proposed regulations in the Human Services Register on March 26, 2004[17] and in the New Mexico Register on April 15, 2004.[18] By contrast, DOH did not publish notice of its proposed repeal until May 28, 2004.[19] By May 28, 2004, HSD concluded its hearing on the proposed PCO regulation changes and was about to publish notice of the final regulations.[20] Given the timing of regulatory action by the two agencies, HSD likely had no knowledge of DOH's intent to repeal the health facility personnel TB rule when it proceeded with adopting the PCO regulation amendments that included a provision based upon DOH's TB standard then in effect.

While HSD's regulations have not evolved on pace with DOH, HSD's intent to adhere to DOH standards is clear. Since the July 31, 2004 repeal by DOH, it appears to have been HSD policy to not enforce the PCO TB rule, as no compliance guidance is readily available and HSD appears to not have audited provider compliance with respect to TB testing. The most telling indication of HSD's position with respect to TB testing is evidenced in its first update to the PCO regulations since 2004. The 2010 changes to the PCO Program regulations include an amendment that provides that PCO provider agency responsibilities include "following current

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[13] State of New Mexico Human Services Department, Medical Assistance Division, MEDICAID PERSONAL CARE SERVICE STANDARDS, IV.B.7 (Mar. 15, 2002).
[14] *See* 27 N.M. Hum. Servs. Reg. 12 (Mar. 26, 2004).
[15] *See* N.M. ADMIN. CODE § 8.315.4.11(A)(37) (2004) ("upon initial employment"); N.M. ADMIN. CODE § 7.4.4(8.1) (2004) ("on first employment").
[16] N.M. ADMIN. CODE § 8.315.4.11(A)(37) (2004).
[17] 27 N.M. Hum. Servs. Reg. 12 (Mar. 26, 2004).
[18] 15 N.M. Reg. 234-235 (Apr.15, 2004).
[19] 15 N.M. Reg. 335 (May 28, 2004).
[20] *See* 27 N.M. Hum. Servs. Reg. 12 (June 9, 2004).

recommendations of the state department of health for preventing the transmission of tuberculosis (TB) for attendants upon initial employment and as needed."[21] This language closely parallels HSD's earlier 2002 rule and confirms that HSD continues to view DOH as the appropriate agency to set TB testing standards. Additionally, while the main purpose of the recently finalized PCO regulation amendments was to clarify the role of the Third Party Assessor ("TPA") and how the Personal Care Option fits into the CoLTS program, HSD appears to have also used the opportunity to "catch up" and update its regulations to conform with what has been department practice since July 30, 2004. HSD said as much in the preamble to the final regulations: "[i]n addition, the entire rule was updated to include program policy changes since the PCO regulations were last filed in 2004."[22]

HSD's actions subsequent to the July 30, 2004 DOH repeal may reflect an acknowledgement that it is not clear that MAD has authority to independently mandate TB testing of PCO attendants. The New Mexico statutes delegating authority to the Human Services Department confer "such powers as may be necessary or appropriate for the exercise of the powers specifically conferred upon it in Chapter 27 NMSA 1978 [relating to public assistance]."[23] The public assistance chapter of the statutes also charges HSD with certain activities, including "the administration of all the welfare activities of the state as provided in [this chapter], except as otherwise provided for by law."[24] Notably, the public assistance chapter of the statutes does not specifically confer upon HSD the authority to prevent the transmission of tuberculosis by Medicaid providers.[25] Rather, it is DOH in which control of communicable diseases has been vested. The New Mexico Public Health Act bestows upon DOH the authority to "maintain and enforce rules for the control of communicable diseases deemed to be dangerous to public health."[26] Moreover, the New Mexico legislature explicitly has assigned responsibility to DOH to determine the communicable disease(s) for which health facility employees must obtain a certification that the employee is free from said diseases in a transmissible form.[27]

Based upon the foregoing, we believe that it is unwarranted for OIG to conclude that HSD failed to ensure Coordinated's compliance with State TB testing requirements. Given the ambiguity in New Mexico regulations and the communications received from State officials, Coordinated acted in good faith in revising its policy to not require TB testing during the OIG audit period.

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[21] 33 N.M. Hum. Servs. Reg. 28 (Aug. 13, 2010) (to be codified at N.M. ADMIN. CODE § 8.315.4.11(B)(31) (effective Sept. 15, 2010). Elsewhere, when defining the responsibilities of consumer-delegated PCO attendants the 2010 amendments require that attendants follow current recommendations of the CDC for preventing the transmission of TB (N.M. ADMIN. CODE § 8.315.4.11(D)(10) (Sept. 15, 2010). This rule is not inconsistent with the agency responsibilities as neither DOH and CDC presently require mass pre-employment TB testing.

[22] *See* 33 N.M. Hum. Servs. Reg. 28 (Aug. 13, 2010).

[23] N.M. STAT. § 27-1-2(B)(7) (emphasis added).

[24] N.M. STAT. § 27-1-3 (emphasis added).

[25] *See* N.M. STAT. § 27-2-12, 27-11-3.

[26] N.M. STAT. § 24-1-3.

[27] *See* N.M. STAT. § 21-1-12 (enacted 1973, last amended 1981).

2. Coordinated has documentation that 99 out of 100 sampled attendants were tested negative for TB.

Even though Coordinated maintains that OIG was substantively wrong to conclude that TB testing is required for PCO attendants in New Mexico, Coordinated is able to demonstrate that 99 of the 100 sampled claims were in substantial compliance with NMAC 8.315.4.11(A)(37).

The ambiguity inherent in the HSD TB regulation has proven frustrating in establishing provider policies and procedures,[28] and as such, Coordinated looked to the CDC for direction on classifying the TB skin test results. The CDC has issued guidance on interpreting tuberculin skin test results which indicates that a TB test is negative where the test results in an induration of 15 mm or less.[29] As the CDC does not recommend TB testing programs for persons not at high risk for TB, the CDC offers no recommendation for the time frame by which an employee should be screened for TB. Nonetheless, it is Coordinated's position that a reasonable interpretation of the HSD TB regulation language "current...upon initial employment" allows for a TB test to have been administered up to one year prior to the date of employment with Coordinated.

Based upon the above criteria, Coordinated can provide documentation that attendants tested negative for TB prior to the dates of service for 84 of the sample claims. In addition, Coordinated is able to provide documentation that attendants tested negative for TB subsequent to the dates of service for an additional 15 of the sample claims. Coordinated asserts that credit should be given for documentation of TB testing subsequent to the sample dates of service, because such tests confirm that the employee was in fact free from transmissible TB on the dates of service. Furthermore, the PCO regulation makes clear that an employee is prohibited from providing services only if the attendant tests positive for TB; a negative test administered subsequent to the sample dates of service proves this was not the case.

B. Annual Training

OIG also has claimed that for 25 of the 100 sampled claims "Coordinated could not provide evidence that the attendants had completed 12 hours of annual training for the calendar year of the dates of service."[30] However, we believe that OIG measured Coordinated's compliance with the attendant annual training requirement on the basis of an inaccurate interpretation of the regulations, thereby discrediting certain evidence of training.

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[28] As mentioned above, HSD never clarified what it means to obtain a "current" TB skin test or chest x-ray or the timeframe encompassed by the phrase "upon initial employment." The HSD regulation also does not specify the threshold induration size resulting from the TB test skin that requires a chest x-ray or other follow up in order to confirm that the individual is free from transmissible TB.

[29] *See* Centers for Disease Control and Prevention, *Fact Sheet: Targeted Tuberculin Testing and Interpreting Tuberculin Skin Test Results* (May 2005), http://www.cdc.gov/tb/publications/factsheets/testing/skintestresults.pdf.

[30] Draft Report at 5.

First, OIG improperly applied a "calendar" year standard in its review of the annual training requirement. New Mexico PCO regulations do not specify which 12-month period constitutes a "year" for the purpose of the annual training requirement. The pertinent regulation requires that attendants receive a certain amount of training "per year," but the term "year" is not otherwise defined. Consequently, providers should have the flexibility to determine which fixed twelve-month period is utilized to tabulate training hours, so long as it is applied consistently.[31] Coordinated monitors annual training compliance on the basis of an attendant's employment anniversary year, and OIG should have used the same basis in auditing Coordinated's annual training records.

Second, in connection with its exit interview with OIG following completion of OIG's audit, Coordinated was led to believe that OIG did not provide credit for the hours attendants spent in CPR and first aid certification courses. However, by its terms, the governing regulation reflects an intention that time spent in CPR and first aid instruction count toward the required hours of training in the year certification is renewed (certification is valid for two years). New Mexico PCO regulations unambiguously state that "attendants must receive a minimum of 12 hours training per year, which must include CPR and first aid."[32]

Third, in at least one instance OIG appears to have disallowed a claim on the basis that the attendant's annual training records did not include evidence of "a test." The only attendant testing required in the context of the PCO program is the competency test administered in conjunction with initial attendant training.[33] Attendant testing is not a requirement of annual training and OIG was erroneous to view it as such.

Measured in accordance with the criteria discussed above, Coordinated can document substantial compliance with the annual training requirements for all 100 sampled claims. Specifically, out of the 25 claims OIG cited for deficiencies in annual training, Coordinated can provide evidence that the attendant(s) providing care with respect to the sample claim had the following hours of annual training: 15 claims with 12 or more hours; 9 claims with 10 – 11 hours; and one claim with 9 hours. We believe that a shortage of 1 to 3 hours of training for no more than 10% of sampled caregivers is an insufficient basis for concluding that Coordinated is not in compliance with State requirements, as it is clear that Coordinated has adequate controls in place and ensured the training requirements were complied with for the overwhelming majority of these claims.

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[31] Allowing use of an attendant's employment anniversary year or a calendar year, at the provider's option, is, moreover, consistent with DOH regulations applicable to determining compliance with personal care attendant training hours for licensed home health agencies. *See* N.M. ADMIN. CODE § 7.28.2.31(C) (referring to attendant's first year of employment).

[32] N.M. ADMIN. CODE § 8.315.4.11(A)(33) (2004) (emphasis added).

[33] N.M. ADMIN. CODE §§ 8.315.4.11(A)(2), (38) (2004).

C. CPR/ First Aid Certification

OIG claimed that for 22 of the 100 sampled claims "Coordinated could not provide evidence that the attendant was certified in CPR and/or first aid on the dates of service."[34]

Coordinated can provide documentation of substantial compliance with the CPR/first aid training requirement for 97 out of the 100 sampled claims. Specifically, documentation evidences that the attendant was certified in CPR and/or first aid on the dates of service for 93 of the 100 sampled claims. Additionally, Coordinated can provide documentation demonstrating that for an additional 4 claims the attendant was out of compliance with the CPR/first aid training requirement for a period of time that was less than three months: for one claim the attendant's certification was renewed within 90 days of the previous certification's expiration, and for 3 claims the attendant obtained the required certification within the first six months of employment, less than three months out from the required time frame. Coordinated believes that a lapse in compliance of three months or less constitutes substantial compliance because the PCO regulations allow newly hired attendants a ninety day grace period during which time they may work without current CPR/first aid certification.

Coordinated further notes that for the 3 claims that may not substantially comply with this requirement, the absence of documented certification more likely reflects a recordkeeping error on Coordinated's part and not that the attendant was without the required lifesaving skills on the sample claim dates of service.

***D. Criminal Background Checks**

[34] Draft Report at 5.

* Office of Inspector General note: This section is not applicable because the finding to which Coordinated referred is not included in this report. As a result, we redacted Coordinated's comments on this finding.

E. Supervisory Visits

With respect to supervisory visits, OIG's Draft Report concluded that for 9 of the 100 sampled claims, "Coordinated could not provide evidence that the attendants' supervisors had

made the required visits."[40] However, Coordinated can document substantial compliance with the supervisory visit requirement for 94 of the 100 sampled claims. Coordinated has documentation of a supervisory visit during the month of the sample claim for 92 of the sampled claims. For one additional claim, documentation reflects that multiple attempts at a supervisory visit were made during the month of the sample claim. For another sample claim, Coordinated can verify documentation that 12 supervisory visits were performed during the year of the sample claim even though a visit was not conducted during the month in which the sample claim services were provided. Under these circumstances it is clear that Coordinated substantially complied with the supervisory visit requirement.

F. Physician Authorization, In-Home Assessment, and Personal Care Services Plan

OIG's Draft Report claimed that for 2 of the 100 sampled claims, "there was no evidence of a physician authorization form for the personal care services. In addition, one of the two claims did not have evidence of an in-home assessment and a PCSP."[41]

OIG erred in citing Coordinated for any deficiencies relating to documentation of physician authorization forms or in-home assessments, as the TPA is obliged to retain these documents, not PCO provider agencies. OIG even stated in its Draft Report that "NMAC requires third-party assessors or their designees to maintain for each recipient evidence of (1) a physician authorization form signed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (section 8.315.4.16A); (2) an in-home recipient assessment (section 8.315.4.16B(1)(a)); and (3) a PCSP (section 8.315.4.16B)." Yet OIG went on to cite Coordinated, not the TPA, for inadequate documentation of a physician authorization form, in-home assessment and/or PCSP. The PCO regulations require the TPA to develop and approve a level of care packet which must include a current physician authorization form (the MAD 075), and it is the TPA that utilizes the physician authorization form to make consumer level of care determinations.[42] Similarly, the PCO regulations require the TPA to conduct the in-home assessments.[43] Nowhere do the PCO regulations explicitly require agencies to obtain and maintain copies of the physician authorization form or in-home assessment from the TPA. In fact, the TPA is expressly precluded by regulation from contracting with a PCO provider agency to carry out the TPA's responsibilities related to in-home assessment and obtaining appropriate documentation of physician authorization.[44] The PCO regulations require only that PCO provider agencies obtain an approved PCSP.[45]

Coordinated can provide PSCPs covering the service dates for 100 out of 100 of the sampled claims.

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[40] Draft Report at 5.
[41] Draft Report at 6.
[42] *See* N.M. ADMIN. CODE § 8.315.4.16(A) (2004).
[43] *See* N.M. ADMIN. CODE § 8.315.4.16(B)(1) (2004).
[44] *See* N.M. ADMIN. CODE § 8.315.4.16 (2004).
[45] *See* N.M. ADMIN. CODE § 8.315.4.16(B)(2)(a) (2004).

G. Unsupported Units Claims

OIG stated that for 2 of the 100 sampled claims, "Coordinated did not have evidence to support the amount of units claimed for attendant services. Specifically, for one claim, there was no timesheet; for the second claim, the number of units on the timesheet was less than the number of units claimed."[46] Coordinated has determined that a simple math error accounts for the discrepancy between the units reflected on the timesheet and the units claimed. The time in and time out was accurately captured on the timesheet but the time was inaccurately totaled. The result is a 0.5 hour overpayment, which Coordinated will repay in addition to repaying the amount corresponding to the claim for which there was no record.

III. Imperfect Compliance with New Mexico Medicaid PCO Provider Participation Requirements Is Not a Valid Basis for Recoupment of Payment for Claims Submitted During the Period of Noncompliance

OIG asserted in its Draft Report that HSD did not always ensure that Coordinated's claims for Medicaid personal care services complied with certain Federal and State requirements and, "[a]s a result, Coordinated received unallowable reimbursement" for certain personal care service claims.[47] OIG continued that, per the Office of Management and Budget, "to be allowable, costs must be authorized or not prohibited by State or local laws or regulations."[48] In order to determine whether any unauthorized or prohibited payments were made to Coordinated for services provided under the PCO program, OIG audited Coordinated's compliance with section 8.315.4 of the New Mexico Administrative Code. Yet, New Mexico law does not require compliance with NMAC § 8.315.4 as a condition of payment for personal care services. Rather, section 8.315.4 of the New Mexico Administrative Code details the conditions for provider participation in the PCO program.

Stated more simply, OIG has confused NMAC § 8.315.4 for conditions of payment, when in fact these regulations reflect conditions of participation.[49] Conditions of participation are "quality of care standards directed towards an entity's continued ability to participate in the [government] program," whereas conditions of payment render the provider ineligible to receive payment of its claims during any period of noncompliance.[50]

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[46] Draft Report at 6.
[47] Draft report at 4.
[48] Draft report at 1, *citing* Office of Mgmt. and Budget, Circular A-87: *Cost Principles for State, Local and Indian Tribal Governments*, Appendix A § C.1.c, 70 Fed. Reg. 51912 (Aug. 31, 2005).
[49] While "Conditions of Participation" is a term of art specific to the Medicare program, the concept can fairly be applied within the Medicaid context, as state Medicaid programs also establish requirements for provider participation. In New Mexico, the general Medicaid conditions of provider participation are found at N.M. ADMIN. CODE § 8.302.1, while those specifically relating to the PCO Program are detailed at N.M. ADMIN. CODE § 8.315.4.
[50] U.S. *ex rel.* Landers v. Baptist Mem. Health Care Corp., 525 F.Supp.2d 972, 978-979 (W.D. Tenn. 2007).

The Tenth Circuit has emphasized that care must be exercised to accurately distinguish between conditions of program participation and conditions of payment because the distinction is central to determining whether repayment can be demanded as a result of noncompliance:

> Conditions of participation, as well as a provider's certification that it has complied with those conditions, are enforced through administrative mechanisms, and the ultimate sanction for violation of such conditions is removal from the government program. Conditions of payment are those which, if the government knew they were not being followed, might cause it to actually refuse payment. [51]

The regulations promulgated by HSD to govern the Medicaid program do not state that compliance with NMAC § 8.315.4 or other provider participation requirements are a prerequisite to payment.[52] Nor are the PCO regulations "so integral to the government's payment decision" as to render them de facto conditions of payment. [53] Therefore, OIG's recommendation for recoupment on the basis of imperfect PCO Program compliance undermines HSD's own administrative scheme for ensuring that Medicaid providers remain in compliance with the participation requirements and for bringing agencies back into compliance when they fall short of what the regulations require.[54]

HSD has developed a detailed system for policing Medicaid provider participation that does not include recoupment of payments as an enforcement tool.[55] HSD conducts periodic reviews to "assess operation of the PCO program and to ensure all program requirements are met related to all applicable state and federal laws and regulations."[56] Following the on-site PCO review, providers are given the opportunity to develop a Corrective Action Plan and may address the deficiencies cited by HSD in its review findings. HSD can accept the provider's Corrective Action Plan, require additional corrective actions, or move to impose administrative sanctions against providers who "fail[s] to correct deficiencies in provider operations within time limits specified by HSD or its designee after receiving written notice of these deficiencies."[57] HSD imposes administrative sanctions pursuant to NMAC § 8.351.2. The types of sanctions available to HSD are: prior approval, education, closed-end agreement, suspension of participation, termination of participation, civil monetary penalties, or reduction of payments due.[58] These regulations also provide criteria by which HSD is to determine the type of sanction to impose, which include: seriousness of the violation(s), number and nature of the violation(s), history of

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[51] U.S. *ex rel.* Conner v. Salina Reg'l Health Ctr. Inc., 543 F.3d 1211, 1220 (10th. Cir. 2008) (citations omitted).
[52] *See* N.M. ADMIN. CODE §§ 8.300.1 – 8.354.2.
[53] *See* Conner, 543 F.3d at 1222 (internal quotations omitted).
[54] *See* Conner, 543 F.3d at 1220.
[55] *See* N.M. ADMIN. CODE § 8.351.2 (2004).
[56] *See* New Mexico Aging & Long-Term Services Department, Report to Coordinated Home Health Care Inc. regarding *Personal Care Option Audit for Compliance* (July 1, 2009) (on file with the author).
[57] *See* N.M. ADMIN. CODE § 8.351.2 (2004).
[58] *See* N.M. ADMIN. CODE § 8.351.2.11 (2004).

prior violation(s) or prior sanction(s), nature and degree of adverse impact of the sanction upon Medicaid recipients, and mitigating circumstances.[59]

HSD's rubric for PCO provider oversight demonstrates that it has adequate safeguards to ensure provider compliance with the PCO Program regulations, and it is preferable to rely on the experience of this State agency to survey compliance. Furthermore, echoing the Tenth Circuit's conclusion in *Conner*, the fact that HSD has established a detailed administrative mechanism for managing PCO Program participation confirms that although HSD considers substantial compliance a condition of ongoing Medicaid participation, it does not require perfect compliance as an absolute condition of receiving or retaining Medicaid payments for services rendered.[60]

In the Draft Report, OIG identified no authority for recommending retroactive recovery of Medicaid payments for services actually rendered on the basis of noncompliance with the PCO Program participation requirements. Nowhere within HSD's general Medicaid or PCO Program participation requirements, billing requirements, or administrative sanctions and remedies regulations does HSD indicate that it can or will recoup payments from providers for deficiencies in complying with PCO provider participation requirements.[61] The only authorization for recoupment in the PCO regulations is "when audits show inappropriate billing for services."[62] The Medicaid general provider policies similarly authorize recoupment for just one occasion, where "[s]ervices billed to MAD [are] not substantiated in the eligible recipient's records."[63] Additionally, the Medicaid sanctions and remedies regulations specifically enable HSD to invoke the recoupment process only for the recovery of overpayments, defined as "amounts paid to Medicaid providers in excess of the Medicaid allowable amount."[64] These regulations indicate that recoupment is to be employed by HSD to redress service-based deficiencies not participatory-based deficiencies. Furthermore, a new provision included in the PCO regulations effective September 15, 2010, states, "[a]n agency that is non-compliant with provider requirements or Medicaid or program policies or procedures may be placed on moratorium by Medicaid or its designee until the PCO agency has demonstrated, to the satisfaction of Medicaid or its designee, full compliance with all requirements of policies and procedures."[65] HSD took the opportunity in the PCO regulation amendments to clarify its enforcement authority with respect to provider requirements and yet included no discussion of recoupment of payments. It is therefore clear that HSD does not intend for provider participation deficiencies to constitute a valid basis upon which to pursue repayment of Medicaid claims. Nor does the New Mexico legislature confer upon HSD the authority to recoup funds in the event

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[59] *See* N.M. ADMIN. CODE § 8.351.2.12(C) (2004).
[60] *See* Conner, 543 F.3d at 1221.
[61] *See* N.M. ADMIN. CODE §§ 8.302.1; 8.315.4; 8.302.2; 8.351.2.
[62] *See* N.M. ADMIN. CODE § 8.315.4.11(A)(14) (2004).
[63] *See* N.M. ADMIN. CODE § 8.302.1.17 (2008).
[64] *See* N.M. ADMIN. CODE § 8.351.2.13 (2004).
[65] *See* N.M. ADMIN. CODE § 8.315.4.25(B) (Sept. 15, 2010).

a Medicaid provider breaches any duty specified in its provider agreement, including complying with the PCO regulations. [66]

Therefore, OIG's conclusion that recoupment is recommended is inconsistent with both federal case law and New Mexico provider participation enforcement standards.

IV. RESPONSE TO OIG'S SAMPLE DESIGN AND METHODOLOGY

Extrapolation of OIG's audit findings for the 100 sampled claim lines to the population of all 277,724 personal care claim lines submitted by Coordinated to Medicaid for the period of October 1, 2006 to September 30, 2008 is inconsistent with New Mexico auditing standards. Specifically, New Mexico's Medicaid program has a long history of not extrapolating the findings of audits that it conducts to a larger universe of claims. Instead, the State Medicaid program has had a policy of only recouping claims on a line-by-line basis. As such, OIG's extrapolation is in conflict with the manner with which New Mexico Medicaid conducts these types of audits.

Coordinated also calls attention to an error in the sample claim data supplied to Coordinated by OIG. Our review of this data identified a decimal point error in the "LINE_PC_UNITS" for at least 27 of the sampled claims. For example, the units corresponding to claim 31 should be 68 not 6.8. Therefore, in addition to our position that almost none of these claims were improperly submitted, even if an extrapolation were to be conducted, these decimal point errors call into question the accuracy of the data from which OIG drew its sample and to which it extrapolated its findings. Coordinated believes this type of error is something that should have been caught by OIG during its data validation process and, therefore, urges OIG to confirm that it has accurate data before issuing its report in final.

V. CONCLUSION

For the reasons articulated above, Coordinated disagrees with OIG's findings that 59 of the sampled claims were deficient and that all of these deficiencies should result in a demand for repayment. Coordinated contends that 90 of the 100 sampled claims are substantially compliant with the New Mexico PCO Program requirements audited by OIG. Coordinated agrees with OIG's findings for 8 out of 100 sampled claims to the extent that deficiencies exist, but disagrees with OIG's recommendation that recoupment should result because simply failing to satisfy one of the conditions of participation is not a basis upon which the claims should be denied. Finally, Coordinated agrees with OIG's findings for 2 out of 100 sampled claims and will make a repayment corresponding to the unsupported units for these two claims. However, Coordinated notes its strong disagreement with extrapolation of these unsupported units to the universe of personal care claims.

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[66] *See* N.M. STAT. § 27-11-3; New Mexico Human Services Department Medial Assistance Division, PROVIDER PARTICIPATION AGREEMENT MAD 335 (Rev. 9/9/03).

While Coordinated agrees with OIG's finding of deficiencies with respect to ten total claims, Coordinated would like to highlight that when the deficiencies that correspond to these ten claims are categorized by type of deficiency, the deficiency rate is 6% or less in each category:

Category	Number of Claims Substantially Compliant	Number of deficiencies
TB Testing	99 out of 100	1
Annual Training	100 out of 100	0
CPR/First Aid Certification	97 out of 100	3
Criminal History Screening	99 out of 100	1
Supervisory Visits	94 out of 100	6
Physician authorization, in-home assessment, PCSP	100 out of 100	0

Therefore, we believe OIG's findings do not suggest any systemic problems or a lack of adequate controls to ensure compliance with State and Federal requirements.

* * *

Again, Coordinated appreciates this opportunity to comment on the Draft Report. Should any additional information be required or further discussion needed regarding the Draft Report, please contact me at (575) 523-8885.

Sincerely,

/s

Judy M. Sanchez
President

Attachments

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

June 18, 2012

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
U.S. 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 Coordinated Home Health

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-06-09-00064 titled "Review of New Mexico Medicaid Personal Care Services Provided by Coordinated Home Health."

Thank you for the opportunity to comment. If you should have any questions, please contact Crystal Hodges, Acting Chief of the CoLTS Bureau at (505) 476-7260 or by e-mail at CrystalA.Hodges@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-06-09-00064 on Medicaid Personal Care Services, Coordinated Home Health

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A. Introduction

In April 2012, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") issued a draft report entitled "Review of New Mexico Medicaid Personal Care Services Provided by Coordinated Home Health," which covered claims from October 1, 2006, through 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 State's Coordination of Long Term Services program ("CoLTS") regarding the claims Coordinated Home Health ("Coordinated") submitted. MAD also requested, received, and reviewed documentation from Coordinated offered in support of its response to the Draft Audit.

B. Summary of Response

MAD strongly disagrees that the OIG's findings support the recommendation of the Draft Audit that the State return $10,962,174 in federal funds paid to Coordinated. The Draft Audit identifies six categories of "deficiencies" with respect to 100 reviewed claims, selected on a random basis. It concludes that the claims (or portions of claims) affected by these "deficiencies" amounted to $7,734 (state and federal share).[1] It then extrapolates this conclusion to the universe of Coordinated's claims for the two-year review period, and arrives at the amount of $10,962,174 in alleged "overpayments" of federal funds during the audit period.

We respectfully disagree with this conclusion. Five of the six categories of "deficiencies," and 45 of the 46 allegedly deficient claims, 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 they were non-compliant with those state requirements.[2] When the State determines that these requirements have not been satisfied, the Quality Assistance Bureau ("QAB") has a policy and practice of issuing corrective action plans to ensure full compliance in the future.[3] To the extent that the OIG relies on OMB Circular A-87 as a basis for its state-law-based disallowance recommendations, MAD notes that A-87 requires only that "costs . . . [b]e authorized or not prohibited under State or local laws or regulations." 2 C.F.R. Pt. 225, App'x A, C.1.c. That is, pursuant to the plain language of this provision,

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[1] The Draft Audit examined only Coordinated's claims for personal care services. 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's 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) (emphasis added).

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

the federal government's ability to recoup turns on state law, and therefore when state law does not require recoupment for the alleged violations at issue, A-87 does not provide a basis for recoupment of federal funds. To the extent that the OIG recommends a federal refund because some of the state law provisions constitute attendant qualifications and 42 C.F.R. § 440.167 requires that personal care services be provided by a qualified attendant, MAD believes that taking a disallowance based on State-imposed qualifications will serve to deter States from imposing (or retaining) attendant qualifications that help protect the health and safety of recipients. It would be unfair and counter-productive to penalize States for voluntarily enacting heightened requirements for personal care attendants, particularly when there is such diversity in the range of attendant qualifications that States currently impose. *See* HHS, Office of Inspector General, States' Requirements for Medicaid-Funded Personal Care Service Attendants ii (Dec. 2006) ("States have established multiple sets of attendant requirements that often vary among programs and by delivery models within programs, resulting in 301 sets of attendant requirements nationwide.").

While MAD acknowledges that the findings support a conclusion that there was a single overpayment of $7.05, it does not support extrapolating that conclusion to the universe 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 Coordinated, the Draft Report identified only one instance of 0.5 hours of overbilling. The OIG's findings here—that overbilling constituted less than 0.05 percent of the $15,079 in claims contained in the audit review—are far too isolated to warrant extrapolation.

Overall, the findings of the Draft Audit reveal a provider that has been generally compliant with applicable requirements. At most, the "deficiencies", which in significant part reflect no more than the inability to document every instance of compliance, warrant the State insisting upon a corrective action plan from the provider. As explained in Coordinated's response letter, it has already voluntarily undertaken actions to ensure documentation of future compliance with the underlying state and federal requirements.

In short, for the reasons detailed above and below, it would be unreasonable for the federal government to require recoupment of over 40 percent of the federal funds ($26,931,344) that Coordinated received during the audit period for administering personal care option ("PCO") services. The use of extrapolation to calculate a recoupment is particularly inappropriate here, where the OIG reviewed only 100 cases (less than 0.04% of the total 277,724 claims) and discovered only one isolated and minor instance of actual overpayment.

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 beneficiary. 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, a state fiscal agent 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 Coordinated Deficiencies

The OIG's Draft Audit concluded that MAD did not always ensure that Coordinated's claims for Medicaid PCO services complied with applicable federal and state requirements. The auditors determined that of the 100 sample claims that were examined, 54 (totaling $6,939) were in full compliance and 46 (totaling $8,140) were not. The auditors further determined that 3 of the 46 non-compliant claims were partially allowable. In sum, the OIG asserts that Coordinated improperly claimed $7,734—$5,536 in federal share—for the 46 sample claims.

The Draft Audit identified 60 alleged deficiencies contained in those 46 claims which fall into the following 6 categories:

- Missing cardiopulmonary resuscitation ("CPR") and/or first aid certification (20 claims)
- Missing documentation of annual training (20 claims)
- Missing documentation of tuberculosis testing (9 claims)
- Missing documentation of supervisory visits (8 claims)
- Unsupported units of payment (2 claims)
- Missing physician authorization (1 claim)

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

[4] The Draft Audit also noted that Coordinated submitted claims for meal preparation and housekeeping services even when the attendant lived in the same home as the beneficiary, though this claiming did not violate either federal or state law in effect at the time.

1. Missing CPR or First Aid Certification

Draft Audit Finding: The OIG auditors determined that in 20 of the 100 sampled claims Coordinated 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 New Mexico Administrative Code ("NMAC"). The purportedly unallowable amount of the claims in question totals $3,235.83.

MAD Response: There is no federal requirement that an attendant be CPR or first aid certified, and even if the state requirement was not complied with, state law does not require withholding payment from providers for the services furnished by the attendant. In most of the purported deficiencies at issue here, Coordinated provided documentation of either CPR or first aid certification covering the time period of the claim at issue, and documentation showing that the attendant was CPR and/or first aid certified for years either before or after the services were rendered. For some of the purported deficiencies, Coordinated also provided documentation establishing that the attendant obtained the missing certification shortly after the services in the sample claim were rendered. These types of "deficiencies" by no means suggest a systemic failure to comply with the State's CPR and first aid requirements.

Since the audit period, Coordinated has centralized recordkeeping of attendant and client files in its corporate office, instead of its regional offices. In its response to this audit, Coordinated asserts in its response that this new system will help it achieve greater compliance with documentation requirements. Further, since the middle of 2008, Coordinated has been utilizing Allscripts® software designed to ensure regulatory compliance, instead of relying on manual controls. Coordinated asserts that Allscripts® will prevent attendants from being scheduled for shifts unless all "compliance fields," including CPR/first aid certification, reflect an up-to-date status.

2. Missing Annual Training Documentation

Draft Audit Finding: The OIG auditors found that for 20 of the 100 sample claims Coordinated lacked documentation showing that attendants had completed 12 hours of annual training in the year in which they furnished services to Medicaid recipients, as required by section 8.315.4.11A(33) of the NMAC. The purportedly unallowable amount of the claims in question totals $3,251.20.

MAD Response: Federal law does not require attendants to undergo a specified amount of training each year, 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 not been fully met, state law does not require withholding payment where the requirement is not met.

For these allegedly deficient claims, Coordinated generally provided documentation that the attendant completed multiple hours of training in the year in which the services were furnished, even if it could not document that the attendant completed the full 12 hours. In many of these cases, Coordinated established that the attendant satisfied the 12-hour requirement either in the prior calendar year or the following calendar year. For example, Coordinated documented that the attendant in sample claim 27 attended 11 hours of training in 2006 (the year in which the sampled services were provided), completed what would have been the 12th hour of training within a month of the end of calendar year 2006, and subsequently completed 12 additional training hours in 2007. Similarly, Coordinated provided

documentation establishing that the attendant in claim 65 completed over 30 hours of training from the beginning of 2007 to the end of 2009, but because she had not completed 12 hours during calendar year 2008, the OIG recommends disallowing of the sample claim.[5] These types of purported deficiencies do not suggest that Coordinated's attendants were unqualified to provide personal care services. Nor do they indicate a widespread failure of Coordinated's attendants to complete training.

Further, as mentioned in more detail above, Coordinated has centralized its recordkeeping of attendant and client files in its corporate office, and begun utilizing Allscripts® to prevent the staffing of attendants who lack documentation of compliance with the annual training requirements.

3. Missing Tuberculosis Testing Documentation

Draft Audit Finding: The OIG auditors found that for 9 of the 100 sample claims Coordinated lacked documentation showing that the attendant had received a tuberculosis ("TB") skin test or chest x-ray and tested negative for TB, as required by section 8.315.4.11A(37) of the NMAC. The purportedly unallowable amount of the claims in question is $2,416.39.

MAD Response: There is no Federal requirement that an attendant receive TB screening, and even if the state requirement had not been met, state law does not require withholding payment from providers for the services furnished by the attendant. Enforcing this type of state requirement by withholding federal funds, when it is otherwise apparent that eligible services were provided to an eligible recipient, is unwarranted. In addition, the OIG's findings do not show a widespread pattern of noncompliance. Coordinated was unable to locate testing documentation for less than 10 percent of the sample claims, and attendants in 4 of the 9 purportedly deficient claims were tested within a year of the claim at issue. The attendants at issue in 8 of the 9 "deficiencies" were later tested; none of the attendants tested positive for TB.

In addition, since the audit period, Coordinated has centralized recordkeeping in its corporate office, and employed new software that monitors attendant qualifications and would prevent attendants from being staffed if they have not undergone the requisite TB testing. Coordinated's response indicates that these corrective measures will help it achieve greater compliance with documentation requirements moving forward.

4. Missing Documentation of Supervisory Visits

Draft Audit Finding: The OIG auditors determined that for 8 of the 100 sample claims Coordinated did not provide evidence that attendant supervisors had met with recipients and/or their personal representatives in the recipients' homes at least once a month, as required by section 8.315.4.11A(31) of the NMAC. The purportedly unallowable amount of the claims in question is $1,132.42.

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[5] The hour totals are based on training quizzes Coordinated provided, some of which indicate that they correspond to one hour of training credit, but others of which are silent as to how many hours of training credit they involve. For the quizzes in the latter category, Coordinated appears to have considered each to have involved one hour of training, and the OIG apparently has not taken issue with this approach. The State sees no reason to question Coordinated's approach and thus considers each quiz as representing one hour of training.

MAD Response: Federal law does not require that providers maintain documentation of monthly attendant supervisor visits; thus, there is no justification for withholding federal funds on this basis. Even assuming that the state requirement was not met, state law does not require withholding payment from providers when such documentation is missing. Under these circumstances, taking a disallowance based solely on a violation of state law is inappropriate, and would only serve to discourage States from voluntarily imposing robust regulatory regimes to govern the provision of personal care services. Nor does this state requirement have any bearing on whether an attendant is "qualified" to provide personal care services for purposes of federal law under 42 C.F.R. § 440.167.

In addition, the OIG recommends recoupment based in part on highly technical violations of this state rule. For example, the OIG recommends recouping sample claim 41 even though Coordinated documented 12 different supervisory visits in calendar year 2007, including at least one in every month other than November 2007, when the sampled services were provided. Similarly, for sample claim 96, Coordinated documented monthly supervisory visits from February 2008 to June 2008, with the exception of March 2008, the month in which the sampled services were provided. For sample claim 48, Coordinated provided documents showing that the supervisor visited the recipient's home 3 times during the month at issue, and called at least once, but each time the beneficiary was not home. Recommending a disallowance based on these types of technical violations is inappropriate and ignores reality, especially for the latter instance in which the supervisor made multiple, good faith efforts to comply with the monthly visit requirement.

5. Unsupported Units of Payment

Draft Audit Finding: The OIG determined that for 2 of the sample claims Coordinated failed to provide documentation supporting the claim for services. The purportedly unallowable amount of the claims in question is $454.65.

MAD Response: Coordinated has conceded that it should not have been paid for the 0.5 hour of services at issue in sample claim 56, and will return that $7.05 to HSD. MAD notes, however, that this overbilling is, at most, an isolated occurrence and the amount of the overpayment is a miniscule percentage of the total claims reviewed. This $7.05 is less than 0.05 percent of the $15,079 in PCO claims contained in the 100 cases included in the audit review.

As for sample claim 79, for which Coordinated was unable to provide documentation supporting $447.60 in services, there is no affirmative evidence that the services in question were not provided. Rather, there was simply a missing timesheet. Considering Coordinated's low rate of misclaiming, the more likely explanation is that Coordinated misplaced the timesheet supporting the services at issue.

In 2008, Coordinated began using Allscripts® to ensure accurate billing. In its response to this audit, Coordinated asserts that this software records the attendant's start and finish time and automatically calculates the hours worked, and also generates weekly reports for any shifts not supported by a timecard, thereby facilitating prompt submission of timecards and preventing the submission of claims without timecards.

6. Missing Physician Authorization

Draft Audit Finding: The OIG auditors found that 1 of the 100 sample claims lacked documentation demonstrating that the recipient had obtained prior physician authorization for the furnished services,

as required by § 440.167 and section 8.315.4.16A(1) of the NMAC. The purportedly unallowable amount of the claim in question is $441.09.

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

7. Other PCO Matters

Draft Audit Finding: The OIG auditors found that for 30 of the sample claims Coordinated charged a total of $1,829 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 provided properly and in compliance with the law. 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 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 Coordinated.

F. Response to Proposed Overpayment Recovery

After concluding that 46 sample claims resulted in overpayments, the Draft Audit extrapolates the total refund due to the federal government, and recommends that New Mexico repay the federal government $10,962,174 for alleged unallowable PCO service claims submitted by Coordinated from October 1, 2006 through September 30, 2008. The State takes strong exception to this recommendation.

As shown above, there is no justification for recovery of any federal funds, with or without extrapolation, with regard to 45 of the 46 questioned claims. For these claims, the findings of the Draft Audit do not support a conclusion that payments were improperly made.

Further, to the extent the absence of documentation in the case file relates to state requirements, rather than to provisions of the federal regulations, 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 Coordinated. To the contrary, the OIG auditors identified only one instance of overbilling, amounting to $7.05 of the total $15,079 in PCO claims reviewed in the audit. This would mean that Coordinated's error rate is only 0.05 percent, far less than the tolerance levels established in various quality control programs in Medicaid and other federally funded programs. *See, e.g.*, 42 C.F.R. § 431.865 (establishing a 3 percent tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program); 42 C.F.R. § 483.25(m) (requiring nursing facilities to be free of medication error rates of 5 percent or greater, and be free of significant medication errors); 45 C.F.R. § 205.42 (1980) (establishing a 4 percent 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 over $10 million 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.

As has been explained to CMS and the OIG in previous communication relating to this and other audits, the State is deeply concerned about the approach the OIG has taken in its four audits of personal care providers in New Mexico. The auditors have transformed every deviation from perfection in the maintenance of case and attendant files that are several years old into a determination of an overpayment, without regard to whether the alleged deficiency is reflective of any mistaken payment to the provider, and have extrapolated these results to the entire universe of claims over an extended period of time to arrive at overpayment recovery recommendations that are utterly disproportional to the actual degree of provider misclaiming. This approach threatens, in the aggregate, to seriously impair the ability of the State to fund its current Medicaid program.

G. Conclusion

While there is always room for improvement, and the State intends to continue its longstanding 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 Coordinated's PCO services. The State would be prepared to repay $5.01, the federal share associated with the sole instance of overbilling.[6]

[6] This amount was calculated by applying the applicable FMAP rate (71.04 percent) for the time period of the claim at issue (August 2008) to the total $7.05 overpayment.

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 began with the PCO Billing and Administrative Workgroup in October 2011. A smaller workgroup, "Continuous Quality Improvement for PCO", was formed and the first meeting was held on April 12, 2012. At this first meeting principles for measures were

identified, and a target date for recommendations was set as July 2012. Members of the group conducted a thorough review of existing measures and adopted the *CMS HCBS Waiver Assurance Domains* and *CMS Quality Framework Domains and Desired Outcomes*. *See* M. Booth, & J. Fralich, , Rutgers Ctr. for State Health Policy, Univ. of S. Maine, *Performance Measurement: Managing and Using Home and Community-Based Services Data for Quality Improvement* (Apr. 2006). Recommendations from members of the CQI group will be presented at the next meeting of the PCO Billing and Administrative Workgroup. 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 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 Coordinated Deficiencies

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

(a) 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.

(b) Annual Training

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

First, the State provides staff training materials and technical assistance electronically to PCO agencies. Guidance on the training requirement, documentation required to demonstrate compliance with the training regulations, and the technical assistance documents provided at trainings are posted to the 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.

(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) 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 held two webinars (October 18, 2011and November 2, 2011) on the revised regulations that went into effect September 2011.

The most recent training for providers by State staff on regulations occurred on May 22, 2012.

(e) Supervisory Visits

Beginning in 2009, the training required of new PCO providers has emphasized the importance of compliance with the State requirement for monthly in-home supervisory visits. Effective December 2010, MAD's revised PCO regulations to clarify this requirement and to specify what content must be included in home visit documentation. Technical assistance documents provided at the trainings and posted on the ALTSD and MAD websites further reinforce this regulatory requirement and provide guidelines for a supervisory home visit.

As detailed above in (b), each CoLTS MCO 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 oversight of the information provided by the MCOs.

The MCOs stipulate in their contractual agreements that PCO agencies are required to abide by all State and Federal regulations, including requiring all agencies to conduct and document the monthly supervisory home visit. As detailed above in the discussion of corrective strategies relating to the TB testing requirement, each MCO has established strategies for assuring compliance with the monthly supervisory home visit requirement.

(f) Physician Authorization

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

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

3. Other PCO Matters

When it revised the PCO regulations in December 2010, MAD introduced a PCO Service Guide to record observations and responses to an individual's functional level and independence to perform ADLs and IADLs. The guide provides an impairment rating system for identifying PCO services and service time

ranges. The guide requires a service coordinator to identify and record whether the beneficiary shares a household with other PCO recipients and name the other PCO recipients. The new PCO rules strengthened the regulations to clarify that duplicative PCO services are not allowed for individuals receiving the same or similar services by other sources, including natural supports.

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.