DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

June 12, 2012

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

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

SUBJECT: Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc. (A-06-09-00117)

Attached, for your information, is an advance copy of our final report on New Mexico Medicaid personal care services provided by Clovis Homecare, Inc. We will issue this report to the New Mexico Human Services Department, Medical Assistance Division, within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00117.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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

June 15, 2012

Report Number: A-06-09-00117

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

Dear Ms. Weinberg:

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

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

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

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Paul Garcia, Audit Manager, at (512) 339-3071 or through email at Paul.Garcia@oig.hhs.gov. Please refer to report number A-06-09-00117 in all correspondence.

Sincerely,

/Patricia Wheeler/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW MEXICO MEDICAID PERSONAL CARE SERVICES PROVIDED BY CLOVIS HOMECARE, INC.

Daniel R. Levinson
Inspector General

June 2012
A-06-09-00117

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

Pursuant to 42 CFR § 440.167, personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for 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 or her personal representative in the recipient's home monthly. The State agency periodically reviews provider agencies to ensure compliance with Federal and State requirements.

The State agency reported to CMS personal care services expenditures of approximately $57.6 million ($44.5 million Federal share) from October 1, 2008, through March 31, 2009. Of that amount, Clovis Homecare, Inc. (Clovis), a personal care services provider in Clovis, New Mexico, received $4,711,258 ($3,638,976 Federal share).

OBJECTIVE

Our objective was to determine whether the State agency ensured that Clovis'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 Clovis's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 claims in our sample, 76

(totaling $20,335) complied with requirements, but 24 (totaling $5,670) did not. Five of the twenty-four claims were partially allowable. The allowable portion of the five claims was $956. The 24 claims contained a total of 28 deficiencies: 21 deficiencies on insufficient attendant qualifications and 7 deficiencies on other issues. As a result, Clovis improperly claimed $4,714 for the 24 claims.

Based on our sample results, we estimated that Clovis improperly claimed at least $404,817 (Federal share) for personal care services during the period October 1, 2008, to March 31, 2009.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $404,817 paid to Clovis for unallowable personal care services and

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

CLOVIS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

Along with its comments, Clovis provided documentation that it did not provide during our review. After reviewing the documentation, we reevaluated some claims and determined that 18 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., tuberculosis testing, supervisory visits, cardiopulmonary resuscitation (CPR) and first aid certifications, physician authorization, and prior approval of legal guardian) did not justify withholding Federal funds because only a small number of files were deficient. The State agency also said that the documentation requirements for four of the six categories (i.e., tuberculosis testing, supervisory visits, CPR and first aid certifications, and prior approval of legal guardian) are not Federal requirements; they are State requirements, which do not require recovery of payments. The State agency acknowledged that the remaining category (i.e., unsupported attendant service units) supports the conclusion that an overpayment was made but said that the deficiency 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'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., tuberculosis testing, CPR and first aid certifications, and prior approval of legal guardian) are actually 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 and to develop a personal care services plan (PCSP). The third-party assessor uses those assessments and the physician authorization forms to prepare recipients' weekly schedule of services, which typically are in effect for 1 year.

Federal and State Requirements

The State agency must comply with Federal and State requirements when determining and redetermining whether recipients are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for 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.

[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).

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

New Mexico Administrative Code (NMAC) section 8.315.4.9(A) states that personal care services are delivered pursuant to a PCSP and (1) include a range of services to recipients who are unable to perform some or all activities of daily living because of a disability or functional limitation(s); (2) permit an individual to live in his or her home rather than an institution and to maintain or increase independence; and (3) include, but are not limited to, bathing, dressing, grooming, and shopping.

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

Personal Care Services Expenditures

The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From October 1, 2008, to March 31, 2009, the FMAP in New Mexico was 77.24 percent. The State agency reported to CMS personal care services expenditures of approximately $57.6 million ($44.5 million Federal share) from October 1, 2008, through March 31, 2009. Of that amount, Clovis Homecare, Inc. (Clovis), a personal care services provider in Clovis, New Mexico, received $4,711,258 ($3,638,976 Federal share).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

This audit covered the $4,711,258 the State agency paid to Clovis for 17,992 claim lines (hereafter referred to as "claims") for the period October 1, 2008, through March 31, 2009. We limited our review of internal controls to the State agency's oversight of personal care services providers and Clovis's procedures for maintaining documentation related to attendants and recipients.

We conducted our fieldwork at the State agency office in Santa Fe, New Mexico; the third-party assessor's office in Albuquerque, New Mexico; and the Clovis office in Clovis, 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, 2008, through March 31, 2009, 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 Clovis to review based on payments for personal care services claims it received (totaling $4,711,258) for the audit period;
- selected a random sample of 100 Clovis claims (Appendix A);
- met with Clovis officials to gain an understanding of Clovis's policies and procedures and of documentation in Clovis's recipient and attendant personnel files;
- obtained recipient documentation from the third-party assessor and Clovis for each sampled item;
- identified the attendant(s) included in each sampled item and obtained documentation Clovis maintained in the corresponding personnel files;
- evaluated the documentation obtained for each sample item to determine whether it complied with Federal and State Medicaid requirements;
- discussed the results of our audit with officials from CMS, the State agency, and Clovis;
- gave Clovis an opportunity to provide any additional support for claims with deficiencies;

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

- estimated the unallowable Federal Medicaid reimbursement paid for the 17,992 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 Clovis's claims for Medicaid personal care services complied with certain Federal and State requirements. Of the 100 sampled items, 76 claims (totaling $20,335) complied with requirements, but 24 (totaling $5,670) did not. Five of the twenty-four claims were partially allowable. The allowable portion of the five claims was $956. The 24 claims contained a total of 28 deficiencies: 21 deficiencies on insufficient attendant qualifications and 7 deficiencies on other issues. As a result, Clovis improperly claimed $4,714 for the 24 sampled items.

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

Based on our sample results, we estimated that Clovis improperly claimed at least $404,817 (Federal share) for personal care services during the period October 1, 2008, through March 31, 2009.

ATTENDANT QUALIFICATION DEFICIENCIES

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 20 of the 100 sampled items, Clovis 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.

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]

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

For 1 of the 100 sampled items, Clovis did not provide evidence that the attendant was certified in CPR and/or first aid on 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 4 of the 100 sampled items, Clovis 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 1 of the 100 sampled items, Clovis did not have evidence to support the number of units claimed for attendant services.

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, Clovis did not provide documentation of a physician authorization.

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

NMAC section 8.315.4.11A(21) requires prior State agency approval for any personal care services provided by the recipient's legal guardian or attorney-in-fact. For 1 of the 100 sampled items, Clovis did not provide evidence that the State agency had issued prior approval.

EFFECT OF DEFICIENCIES

Based on our sample, we estimated that Clovis improperly claimed at least $404,817 (Federal share) for personal care services.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the $404,817 paid to Clovis for unallowable personal care services and

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

CLOVIS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, Clovis disagreed with most of our findings. Clovis's comments, which we summarize below, are included in their entirety as Appendix D.[3]

Along with its comments, Clovis provided documentation that it did not provide during our review. After reviewing the documentation, we reevaluated some claims and determined that 18 complied with Federal and State regulations.[4] We revised the findings and recommendations accordingly.

Conditions of Payment Versus Conditions of Participation

Clovis Comments

Clovis stated that recoupment is not an appropriate remedy for the deficiencies noted in the report because compliance with personal care services [5] regulations is not a condition of payment; it is a condition of participation. Clovis stated that in the context of the False Claims Act, courts have frequently held that a provider is not liable for repayment or recoupment for failures to comply with governmental regulations "unless, as a result of such acts, the provider knowingly asked the government to pay amounts it did not owe." Clovis added that personal care services regulations support recoupment of payments only when there is inappropriate billing of services in accordance with NMAC section 8.315.4.11(A)(14) and that the basis for recoupment is not triggered by the various alleged deficiencies outlined in the draft report (pages 2 to 3).

[3] Clovis did not head its comments by finding (e.g., "TB Testing," "Unsupported Units Claimed"). In our summary of Clovis's comments below, we provide page references to Appendix D to assist the reader.

[4] 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.

[5] In its comments on our report, Clovis used the terms "PCO" and "personal care option," which are synonymous with the term "personal care services" that we used throughout the report. For consistency, we will use only the term "personal care services."

Office of Inspector General Response

To provide a valid and payable service, personal care services must meet Federal requirements in section 1905(a)(24)(B) of the Act and implementing regulations at 42 CFR § 440.167, which require personal care services to be provided by a qualified attendant. To be a qualified attendant in New Mexico, the attendant must meet the NMAC requirements related to the attendant qualifications discussed above. Therefore, the NMAC attendant qualification requirements are conditions of payment because an attendant who is not qualified cannot provide valid personal care services as defined by Federal statutes and regulations. 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.

Substantial Compliance

Clovis Comments

Clovis stated that it was in substantial compliance with personal care services regulations. Clovis said that the Tenth Circuit Court of Appeals had observed that perfect compliance was not a necessary condition to receive Medicare reimbursement and that it believes the same is true for Medicaid reimbursement. Clovis stated that at no time was the health or safety of any client at risk, nor was care provided in a manner that would cause harm to its clients. Clovis added that we failed to apply a reasonableness standard to compliance with the regulations. Specifically, we failed to acknowledge that Clovis had a 94-percent or better compliance rate for nearly each of the six categories that we reviewed. Clovis stated that many of the technical deficiencies that were noted relate to requirements that the New Mexico Human Services Department does not impose on personal care attendants under the consumer-directed care model (pages 4 to 5).[6]

Office of Inspector General Response

We evaluated each sample item for compliance with Federal and State regulations. In addition, we based the attendant qualification deficiencies cited in the report on significant service-related requirements. Taken as a whole, these deficiencies are sufficiently numerous and widespread to be considered more than just technical deficiencies; they are quality of care issues. In addition, all 17,992 claims in Clovis' population were for services related to the consumer-delegated model.

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

Sampling Methodology

Clovis Comments

Clovis stated that our recommendation for recoupment using an extrapolation ratio of 1 to 179 (i.e., our sample of 100 out of 17,992 claims) was unprecedented in New Mexico and added that it disputed the statistical validity of both our sample size and extrapolation.

Clovis said that we appeared to have chosen a sample of 100 claims, not based on any statistical analysis of the variance, or heteroskedasticity, of the pool but on the assumption that this would be sufficient and, perhaps, on the simplicity of using a round number. Clovis added that this methodology is contrary to accepted statistical methodology, as well as to the guidance provided in the CMS *Medicare Program Integrity Manual*.

Clovis also stated that our sample rate of 0.556 was insufficient to support our conclusions because the number of claims (17,992), attendants (1,114), and clients (735) during the sample period would be expected to exhibit variance. Clovis stated that the results demonstrate the intrinsic variability of the sample and the need for additional sampling. Clovis stated that the high variability and small sample size yielded unreliable results when extrapolated to the universe of claims (pages 6 to 7).

Office of Inspector General Response

Courts have long upheld the validity of using sampling and extrapolation in audits of Federal health programs.[7] In particular, one court found that "[p]rojection of the nature of a large population through review of a relatively small number of its components has been recognized as a valid audit technique."[8] Courts have not determined what percentage of the entire universe must be sampled for a projection to be held valid;[9] however, the type of sample used here—a simple random sample—is recognized as valid for extrapolation purposes.[10] Further, such statistical sampling and methodology may be used in cases seeking recovery against States, individual providers, and private institutions.[11]

[7] See, e.g., *State of Georgia* v. *Califano*, 446 F. Supp. 404, 409-410 (N.D. Ga. 1977) (a ruling that sampling and extrapolation are valid audit techniques for programs under Title IV of the Social Security Act); *Ratanasen* v. *California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993) (a 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) (a ruling that random sampling and extrapolation were valid statistical techniques for calculating Medicaid overpayments claimed against an individual physician).

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

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

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

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

We did rely on a statistically valid sample.[12] In *Sample Design in Business Research*, W. Edwards Deming (1960) states: "An estimate made from a sample is valid if it is unbiased or nearly so and if we can compute its margin of sampling error for a given probability." We select our samples according to principles of probability (every sampling unit has a known, nonzero chance of selection). We use the difference estimator (an unbiased estimator) for monetary recovery and recommend recovery at the lower limit of the 90-percent, two-sided confidence interval. We use the sampling error in the computation of the 90-percent, two-sided confidence interval. In addition, the term "heteroskedasticity" is ordinarily used in time series or regression analysis; because we used a simple random sample and the difference estimator to arrive at the estimates in the draft report, this term is not relevant.

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

The sampling frame for our sample was 17,992 personal care services related to direct attendant care (procedure code T1019) for which Medicaid paid Clovis during the period October 1, 2008, through March 31, 2009. From that list, we selected 100 services for our sample.

Tuberculosis Testing

Clovis Comments

Clovis provided the following points regarding TB testing:

- Clovis stated that it had submitted documentation supporting negative TB test results for some of the sample items in the "Tuberculosis Testing" section of the report (page 1, paragraph 2).

- Clovis stated that, since the Office of Inspector General audit, it has tested sampled attendants it still employs and that these TB tests were negative (page 4, paragraph 2).

- Clovis stated that some of its attendants were not required to have a TB test because they were hired before the effective date of the regulation in 2004 and that the requirements in the regulations were not retroactive (page 8, paragraph 1).

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

- Clovis stated that it believed the TB testing requirement had been repealed because of a letter it received from the New Mexico Department of Health, which 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" (pages 8-9, section f).

Office of Inspector General Response

Our responses to Clovis' statements regarding TB testing are as follows:

- The negative TB test results that Clovis provided addressed some of the deficiencies in the report. We reduced the deficiencies noted in the report accordingly.

- We did not accept Clovis' assertion that negative TB test results obtained subsequent to this audit for attendants still employed complied with NMAC section 8.315.4.11A(37). Accordingly, we counted a sample item as deficient if Clovis could not provide medical documentation that the attendant tested negative for TB from a TB skin test or chest x-ray prior to the date of service.

- We confirmed with the State agency that attendants hired before the effective date of the regulation in 2004 and without a TB test should not be included in our report. We revised the report accordingly.

- We forwarded the letter mentioned in Clovis' comments to the State agency, which responded that the letter did not apply to personal care services and that TB testing was still required.

Cardiopulmonary Resuscitation and First Aid Certifications

Clovis Comments

Clovis stated that (1) it provided documentation of certifications effective for the dates of service for one claim (page 2, paragraph beginning on page 1) and (2) for two claims, the attendant became certified within the first 3 months of employment, which was in accordance with the regulation (pages 9 to 10, section g).

Office of Inspector General Response

The documentation Clovis provided for the three claims cited above met the requirement to obtain either (1) valid certifications for the dates of service or (2) certifications within 3 months of the attendant's hire date. We reduced the deficiencies noted in the report accordingly.

Supervisory Visits

Clovis Comments

Clovis's comments discussed three claims related to supervisory visits. Specifically:

- Clovis stated that one recipient was visited 8 of 9 months and that two unsuccessful attempts were made for the month of the claimed date of service. Clovis said that supervisory visits were difficult because of its largely rural service area (page 6, paragraph 3).

- Clovis stated that it provided a mileage log entry as documentation of an attempted supervisory visit during the month of the date or service (page 10, section h).

- Clovis stated that services for the recipient ceased in November 2008 and resumed on January 21, 2009.[13] Although the supervisory visit did not occur in January 2009, it did occur within 30 days of services resuming and thus met the requirement for a monthly supervisory visit (page 10, section h).

Office of Inspector General Response

Our responses to the three claims are as follows:

- 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.

- Because Clovis provided with its response a supervisory visit document that was completed for the month of the date of service, we removed one deficiency from the report.

- Because the services restarted in the month of the date of service and the supervisory visit was completed within 30 days of services restarting, we removed one deficiency from the report.

Unsupported Units Claimed

Clovis Comments

Clovis stated that it had provided documentation for the claims listed in the "Unsupported Units Claimed" section of the report.

Office of Inspector General Response

Clovis provided supporting documentation for one claim, and we reduced the deficiencies noted in the report accordingly. For the other claim, we maintain that our finding is correct because the hours claimed exceeded the weekly limit on the recipient's PCSP.

[13] Office of Inspector General Note: The date of service for the claim was January 31, 2009.

Physician Authorization

Clovis Comments

Clovis stated that it had provided documentation for the claim listed in the "Physician Authorization" section of the report (page 2, paragraph 1).

Office of Inspector General Response

The physician authorization documentation provided by Clovis for this claim was not for the appropriate PCSP year. Specifically, the PCSP for this claim was for the 1-year period August 17, 2007, to August 16, 2008, which was extended through October 18, 2008. Clovis provided physician authorizations dated June 27, 2006, and June 11, 2008. Neither of these authorizations was for the PCSP period that began August 17, 2007.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

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

The State agency said that five of the six categories of deficiencies (i.e., tuberculosis testing, supervisory visits, CPR and first aid certifications, physician authorization, and prior approval of legal guardian) involved no demonstrated overpayments and that the deficiencies did not justify withholding Federal funds. Rather, the findings revealed that a few files were missing a document necessary to satisfy a particular requirement for otherwise eligible services. The State agency also said that the documentation requirements in question for four of the six categories (i.e., tuberculosis testing, supervisory visits, CPR and first aid certifications, and prior approval of legal guardian) are not Federal requirements; they are State requirements, which do not require recovery of payments.

The State agency agreed that although one category (i.e., unsupported attendant service units) supports the conclusion that a single overpayment was made, this deficiency does not support extrapolating the overpayment to all claims submitted during the 5-month review period. The State agency added that this finding is too isolated, and is clearly an aberration from Clovis's normal practices. The State agency said that the overpayment was less than 0.08 percent of all claims reviewed in the audit, far less than the tolerance limits established in certain Federal programs.[14] The State agency added that in these programs, standard Federal policy in such circumstances is to seek recovery only for the overpayments identified and not to extrapolate the results.

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

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

Office of Inspector General Response

The deficiencies cited in the report, including tuberculosis testing, supervisory visits, CPR and first aid certifications, physician authorization, and missing prior approval of legal guardianship, are based on significant service-related requirements. Taken as a whole, these deficiencies are too numerous to be dismissed as just a few missing 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 above were not Federal requirements. To provide a valid and payable service, personal care services must meet Federal requirements in section 1905(a)(24)(B) of the Act and implementing regulations at 42 CFR § 440.167, which require personal care services to be provided by a qualified individual. To be qualified in New Mexico, an attendant must meet the NMAC requirements related to the attendant qualifications discussed above. Therefore, an attendant who does not meet the NMAC attendant qualification requirements cannot provide valid personal care services as defined by Federal statutes and regulations. We based other determinations of deficiencies on regulatory requirements that are integral to the definition of personal care services and that must be met for the services to be payable as medical assistance.

We disagree with the State agency regarding the missing documentation of supervisory visits. The State requires that personal care services agencies be contracted 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, Clovis 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 the methodology we used to evaluate the results of that sample have resulted in an unbiased extrapolation (estimate) of Clovis's personal care services. As stated in New York State Department of Social Services, DAB No. 1358 (1992), "… sampling (and extrapolation from a sample) done in accordance with scientifically accepted rules and conventions has a high degree of probability of being close to the finding which would have resulted from individual consideration of numerous cost items and, indeed, may be even more accurate, since clerical and other errors can reduce the accuracy of a 100% review."

As we discussed above in our response to Clovis under the section entitled "Sampling Methodology" (page 8), the Clovis sample was selected according to principles of probability. In addition, the use of sampling and extrapolation in audits of Federal health programs has long been approved by courts.

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 25 of the 100 sampled items, we found that $2,404 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 Clovis Homecare, Inc. (Clovis), for Federal Medicaid reimbursement by New Mexico for the 6-month period October 1, 2008, through March 31, 2009. A claim line represented unit(s) of service paid (0.25 hour equaled one unit of service).

SAMPLING FRAME

The sampling frame consisted of 17,992 personal care services claim lines (totaling $4,711,258) for the period October 1, 2008, through March 31, 2009.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame from 1 to 17,992. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

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

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sampling Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Claim Lines With Deficiencies	Value of Claim Lines With Deficiencies (Federal Share)
17,992	$3,638,976	100	$20,086	24	$3,641

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

Point estimate	$655,042
Lower limit	404,817
Upper limit	905,267

APPENDIX C: REASONS FOR DEFICIENT CLAIM LINES

1	Missing evidence of tuberculosis testing
2	Missing evidence of cardiopulmonary resuscitation
3	Missing evidence of supervisory visits
4	Unsupported units claimed
5	Missing evidence of physician authorization
6	Missing evidence of State agency prior approval for personal care services provided by legal guardian or attorney-in-fact

No.	1	2	3	4	5	6	No. of Deficiencies	Sample Item No.[1]
1	X						1	2
2			X				1	4
3	X						1	12
4	X						1	15
5	X						1	23
6	X		X				2	26
7	X						1	30
8	X						1	32
9	X						1	36
10	X						1	41
11			X				1	42
12	X						1	46
13	X						1	48
14				X	X		2	54
15	X						1	55
16	X						1	71
17	X						1	74
18	X		X				2	78
19	X						1	83
20	X						1	88
21	X						1	90
22	X						1	94
23		X				X	2	95
24	X						1	99
Total	20	1	4	1	1	1	28	

Total deficiencies for “Attendant Qualifications” (columns 1 and 2) is 21.
Total for “Other Deficiencies” (columns 3 through 6) is 7.

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

APPENDIX D: CLOVIS COMMENTS

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November 8, 2010

File No. 1833-001

VIA EMAIL & OVERNIGHT DELIVERY
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Re: Clovis Homecare, Inc.
OIG Report Number: A-06-09-00117

Dear Ms. Wheeler,

We represent Clovis Homecare, Inc. ("Clovis"). We write in response to your letter to Mr. Randie Hatley dated August 26, 2010, enclosing the U.S. Department of Health & Human Services, Office of Inspector General's (the "OIG") Draft Report entitled *Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc.* (the "Draft Report"). Clovis appreciates the opportunity to submit this response in order to raise several issues regarding the Draft Report, its conclusions and recommendations. In light of the analysis set forth below, we believe Clovis only has 27 deficiencies and we respectfully request that the OIG revise its conclusions and recommendations accordingly.

Under separate cover, Clovis submitted several of the documents listed as "missing" in the Draft Report[1]. For sample item numbers 19, 20, 34, 37, 42, 57, 83, 90,[2] 91, 96[3] and 97, Clovis

[1] The additional documents described in this paragraph were all submitted under separate cover dated November 5, 2010. To the extent those documents are subject to the Freedom of Information Act ("FOIA"), they are protected from release under FOIA exemptions (b)(4), (b)(6) and (b)(7).

[2] Sample item numbers 83 and 90 relate to the same attendant, and therefore the same test. For sample numbers 57 and 83/90, the tests in Clovis' file show that the Portales Health Office and Quay County Department of Health, respectively, did not "certify" the tests until several years after the negative tests were performed. We strongly dispute that this discrepancy should in any way invalidate the negative tests because, as both tests indicate, their results are, in fact, certified by the appropriate health officials.

[3] For sample item numbers 20 and 96, the Annual Known Positive TB Reactor Questionnaires have been submitted with the last x-ray readings and other documentation indicated therein. Both Questionnaires are certified by the N.M. Department of Health and both indicate that the attendants had prior positive TB skin tests with subsequent negative x-ray readings. For both attendants, the negative x-ray readings pre-dated the dates of service at issue in the audit, as well as the attendants' dates of hire.

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submitted the attendant tuberculosis ("TB") tests that pre-date the dates of service at issue. For sample item number 32, Clovis submitted the attendant's cardiopulmonary resuscitation and first aid ("CPR/FA") certifications effective on the date of service. For sample item numbers 54 and 77, Clovis submitted the timecards for the dates of service at issue. This clears the only two deficiencies identified in the Draft Report related to units claimed. For sample item number 54, Clovis also submitted the physician authorization applicable to the dates of service at issue. This likewise clears the only deficiency identified in the Draft Report related to physician authorization. In total, then, Clovis has located and provided under separate cover the necessary documents to clear 15 of the alleged deficiencies.

I. Concerns Regarding the Draft Report and Recommendations

Certain of the findings and recommendations in the Draft Report do not appear to be consistent with applicable law and/or reasonable interpretations of applicable law under the facts at issue here, as described in detail below. We also have concerns regarding certain aspects of the methodology used to perform the review.

a. Conditions of Payment v. Conditions of Participation

The Draft Report alleges that Clovis was deficient concerning several personal care option ("PCO") regulations and recommends recoupment of Medicaid dollars. Recoupment is not an appropriate remedy for the alleged deficiencies because compliance with the PCO regulations is a condition of participation and not a condition of payment. Conditions of participation are those requirements providers must meet in order to participate in the Medicaid program. Courts have frequently held, in the False Claims Act context, that a provider is not liable for repayment or recoupment for failures to comply with government regulations "unless, as a result of such acts, the provider knowingly asked the government to pay amounts it did not owe."[4]

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

> To allow FCA suits to proceed where government payment of Medicare claims is not conditioned on perfect regulatory compliance-and where HHS may choose to waive administrative remedies, or impose a less drastic sanction than full denial of payment-would improperly permit qui tam plaintiffs to supplant the regulatory discretion granted to HHS under the Social Security Act, essentially turning a discretionary denial of payment remedy into a mandatory penalty for failure to meet Medicare requirements.[5]

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

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

In affirming the Kansas District Court, the Tenth Circuit explained that "[e]ven if, as the result of the survey, a provider appears noncompliant, the government does not immediately suspend Medicare enrollment or billing privileges. Rather, the relevant regulations permit the provider to create a plan of correction, and allow a reasonable period of time-usually 60 days-to address any deficiencies."[6] The Tenth Circuit also noted that there are no regulations or case law "indicating that the government normally seeks retroactive recovery of Medicare payments for services actually performed on the basis that the noncompliance rendered them fraudulent."[7]

The same is true here. Clovis did not seek payment from the New Mexico Human Services Department ("HSD") for types of services that Medicaid does not cover and all services were provided to Medicaid beneficiaries as claimed. Moreover, in almost every case, Clovis fully and completely adhered to the provisions of HSD's Medical Assistance Division ("MAD") provider participation agreement and all applicable statutes, regulations, billing instructions and executive orders. Further, as discussed below, Clovis has conducted an internal review and created a plan of correction to address the deficiencies noted by the OIG.

Reviewing the New Mexico regulations as a whole, we could not find support for the position that payment for services is conditioned upon strict compliance with every aspect of the PCO regulations at NMAC 8.315.4.11A (2004)[8]. The only discussion of recoupment is contained at NMAC 8.315.4.11(A)(14) (2004). This subsection states that PCO agencies must pass random and targeted audits conducted by HSD or its audit agent to ensure that the agencies are billing appropriately for services rendered. The regulation also expressly states that "the department or its designee will seek recoupment of funds from agencies when audits show inappropriate billing for services."[9] Given the documents located and submitted under separate cover on November 5, 2010, this basis for recoupment is no longer triggered by the remaining alleged deficiencies outlined in the Draft Report. Indeed, historically, HSD has used corrective action plans, sanctions or a combination of both – but *not* repayment - to address providers' deficiencies in compliance with conditions of participation.[10] We understand that this remains HSD policy.

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

[7] *Id.*

[8] The audit period pre-dated the promulgation of the revised PCO regulations late this year. As a result, the PCO regulations cited here are those promulgated in 2004.

[9] NMAC 8.315.4.11(A)(14) (2004).

[10] *See* NMAC 8.351.2 (2003) (Sanctions and Remedies). The Draft Report makes no suggestion and presents no evidence that any of the alleged deficiencies are due to fraudulent conduct by Clovis. Therefore, even under the sanctions and remedies available to HSD for violations of conditions of participation, the penalties to which Clovis would be subject are limited.

b. Substantial Compliance

At all times during the audit period, Clovis was in substantial compliance with the PCO regulations. For Medicaid survey and certification purposes, "substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."[11] As the Tenth Circuit has observed, "although the government considers substantial compliance a condition of ongoing Medicare *participation,* it does not require perfect compliance as an absolute condition to receiving Medicare *payments* for services rendered."[12] The same is true here regarding Medicaid participation and payments – perfect compliance is *not* required. Moreover, the OIG has not demonstrated that strict adherence to every aspect of the regulation at issue guarantees better care for clients.[13] Importantly, at no time was the health or safety of any client at risk nor was care rendered in such a manner that would cause harm to Clovis' clients.

Several examples illustrate this point. First, as to potential TB exposure, Clovis' records demonstrate that all attendants answered an annual TB questionnaire, reviewed by a nurse, to determine whether any of the attendants showed any sign of TB. Thus, while Clovis did not have a record of negative TB tests for certain attendants, Clovis nevertheless closely monitored its attendants every year as to any potential signs of TB. Clovis' constant monitoring, which is documented, ensured the continuing safety of its clients, likely more effectively than a test only upon initial hire. Moreover, since the OIG's audit, Clovis has tested the attendants identified in the audit that it still employs who were actually missing TB testing. All of the attendants' TB tests were negative.[14] Similarly, as to sample item number 95, the lone deficiency regarding approval of attendants serving as clients' legal guardians, note that the New Mexico Aging and Long-Term Services Department recently approved of the attendant simultaneously serving as the client's guardian and attendant. This approval, while belated, demonstrates that the client was not put in harm's way by the arrangement.

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[11] 42 C.F.R. § 488.301.

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

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

[14] These negative test results were submitted under separate cover.

Additionally, the OIG failed to apply a reasonableness standard to compliance with the regulations. New Mexico's Medicaid regulations are comprehensive and are intended to provide policies related to various aspects of Medicaid program operations, such as those regarding provider eligibility, covered and non-covered services, utilization review, and provider reimbursement.[15] The OIG based its audit on a review of isolated portions of the regulations and failed to take into account the language and intent of the regulations as a whole. Furthermore, even using the numbers initially identified as deficiencies by the OIG, the Draft Report wholly fails to acknowledge that Clovis had a 94 percent or better compliance rate for nearly every one of the six categories the OIG reviewed.[16] Moreover, as demonstrated herein, the number of deficiencies identified in the Draft Report was significantly overstated and the actual compliance rate is even higher.

It is important to note that many of the technical deficiencies described in the Draft Report relate to requirements that HSD does not impose on personal care attendants in the virtually identical Consumer-Directed PCO program. It does not seem rational to assert that Clovis' claims should be denied for a regulatory deficiency when identical services provided in the sister Consumer-Directed PCO program would be fully reimbursable.[17] Certainly Clovis' clients would have been at a greater risk of harm by not receiving services at all. We believe that Clovis was in substantial compliance with the spirit and intent of applicable New Mexico law.

c. Barriers to Accessing Health Care Providers and Services

The areas where Clovis' offices are located and where Clovis' patients reside are sorely underserved by health professionals. Clovis' four offices are located in Clovis, Roswell, Ruidoso, and Tucumcari, New Mexico, each of which is designated by the Health Resources and Services Administration ("HRSA") as primary care Health Professional Shortage Areas ("HPSAs") and Medically Underserved Areas ("MUAs"). The eight counties Clovis serves - Chaves County, Curry County, De Baca County, Guadalupe County, Lincoln County, Otero County, Quay County, and Roosevelt County - are also designated as primary care HPSAs. Seven of these - Chaves, Curry, Guadalupe, Lincoln, Otero, Quay, and Roosevelt Counties - are designated as MUAs. De Baca County is designated as having a Medical Underserved Population ("MUP") at the request of New Mexico's Governor based on documented unusual local conditions and barriers to accessing personal health services.[18]

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[15] NMAC 8.315.4.6 (2004).

[16] *See infra.*

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

[18] The status of these areas as HPSAs, MUAs, or MUPs was confirmed through a search of HRSA's databases, which can be found at http://bhpr.hrsa.gov/shortage/. A HPSA is an area in an urban or rural area that the Secretary of the U.S. Department of Health & Human Services determines: (1) has a health manpower shortage and that is not reasonably accessible, (2) has a population group that the Secretary determines has such a shortage, or (3) has a public or nonprofit private medical facility or other public facility that the Secretary determines has such a shortage. A primary care HPSA means that there is a shortage of doctors of medicine and osteopathy providing direct patient care who practice principally in one of the four primary care specialties -- general or family practice, general internal medicine, pediatrics,

As a result of working in these officially designated underserved areas, it is particularly difficult for Clovis' attendants to access facilities that offer TB testing. Also, attendants frequently are family members of Clovis' clients and provide many services outside of the personal care arena to their family member, which generally require them to stay home with their family member. Under the circumstances, these attendants' responsibilities make it extremely difficult for them to obtain TB tests because they often have to travel lengthy distances over rural roads at least twice in connection with each TB test.

Attendants similarly have difficulty traveling to Clovis' offices to receive CPR/FA certification training. Such training is largely unavailable in the attendants' communities and receiving training at a Clovis office is the only option. Attendants in Clovis' more isolated service areas travel an average of 74 miles one way to reach a Clovis office to receive training. These individuals often have unreliable transportation, lack money to pay for gasoline, and, as discussed in the paragraph above, have difficulties traveling because of obligations to Clovis clients. Yet, Clovis has a 96 percent compliance rate for CPR/FA certification training.

Similar difficulties plague the monthly supervisory visits. With a largely rural client-base, Clovis supervisors spend significant time traveling long-distances to visit with clients. In fact, these trips often occur more than once per month when clients are not at home during the initial visit. Yet, again, despite these difficulties, Clovis has at least a 94 percent compliance rate for supervisory visits. Moreover, when the files are viewed as a whole, it is clear that even in the limited instances when a supervisory visit was missed, it was the rare exception. For instance, when looking at a nine month window of time for sample number 78, it becomes clear that Clovis successfully visited the client eight out of nine months and, for the single month without a visit, Clovis made at least two unsuccessful attempts.

We believe that the HPSA, MUA, and MUP designations and the fact that Clovis operates and serves clients who reside in officially designated underserved areas are critical factors in any assessment of compliance with the regulations, particularly when applying a reasonableness standard to the alleged deficiencies identified.

d. Sampling and Extrapolation

The Draft Report relies on a sampling of 100 out of 17,992 claim lines, and then makes a recommendation for recoupment using an extrapolation ratio of 1 to 179. Historically, HSD does not extrapolate from its audit findings. To our knowledge, this is equally true of the other New Mexico Departments. Even if extrapolation was permissible and supported by New Mexico law,

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and obstetrics and gynecology. 42 U.S.C. § 254e. An MUA is an urban or rural area or population that: (1) is a HPSA, (2) is eligible to be served by a migrant health center, a community health center, is a grantee relating to homeless individuals, or a grantee relating to residents of public housing, (3) has a shortage of personal health services, or (4) is designated by the Governor as a shortage area or medically underserved community. 42 U.S.C. §§ 254c-14 & 295p. An MUP is the population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated as having a shortage of such services. 42 U.S.C. § 254b.

Clovis disputes the statistical validity of both the sample size and the extrapolation in the Draft Report.

The OIG's statistical analysis suffers from *prima facie* errors that render it incapable of supporting the Draft Report's recommendations. The OIG appears to have chosen a sample of 100 claims, not based on any statistical analysis of the variance or heteroskedasticity of the pool (which is the ordinary procedure for statistical sampling), but instead appears to have chosen 100 sample claims based on the assumption that this would be sufficient (perhaps, based on the simplicity of using a round number).[19] This is contrary to well-accepted statistical methodology as well as the guidance provided in the CMS Program Integrity Manual.[20]

The OIG's 0.556 percent sample rate is insufficient to support its conclusions. The records for a company with approximately 1,114 attendants, 735 clients,[21] and 17,992 claims during the sample period would be expected to naturally exhibit variance. Indeed, the results demonstrate the intrinsic variability of the sample and the need for additional sampling. Here, the high variable and small sample size yields unreliable results when extrapolated to the universe of claims.[22]

e. Prospective v. Retrospective Application of Regulations

The Draft Report applies certain PCO regulation requirements retroactively, resulting in at least five deficiencies against Clovis. This retroactive application is contrary to both New Mexico law and the applicable PCO Regulations. The sampling period underlying the Draft Report was from October 1, 2008, through March 31, 2009. The PCO Regulations applicable to the services rendered during that time were the 2004 PCO Regulations promulgated on February 1, 2004 (the "2004 Regulations").[23] The PCO Regulations applicable to the hiring requirements for attendants, on the other hand, depend on the date each attendant was hired. Because the 2004 Regulations did

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[19] For example, *see*, "Review of Personal Care Services Claimed by the Center for Living and Working, Inc.," (A-01-06-00011), sample size= 100, universe= 4,466 payment years; "Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 Through September 30, 1999," (A-05-01-00044), sample size= 100, universe= 211,000 claims.

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

[21] The number of attendants provided is for all of 2009; the number of clients provided is as of March 31, 2009, i.e. the end of the audit period.

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

[23] NMAC 8.315.4 (2004).

not become effective until July 1, 2004,[24] the initial hiring requirements for attendants hired before that date would fall under the original PCO Regulations (the "Original Regulations").[25]

Of the samples identified in the Draft Report that were allegedly missing evidence of tuberculosis testing, the attendants for sample item numbers 20, 49, 52, 58 and 96 were all hired before the effective date of the 2004 Regulations and thus were subject to the Original Regulations. This is important because the Original Regulations did not require tuberculosis testing upon initial employment.[26] Further, under New Mexico law, the 2004 Regulations' tuberculosis testing requirement was not retroactive. "New Mexico law presumes that statutes and rules apply prospectively absent a clear intention to the contrary."[27] Here, there is no suggestion, clear or otherwise, that the 2004 Regulations were to be applied retroactively. Indeed, the text of the regulation itself counsels against retroactive application by stating that while July 1, 2004, is the effective date, "a later date" may also be appropriate if "cited at the end of a section."[28] HSD's decision to apply the 2004 Regulation requirements prospectively was especially appropriate because many of the changes in the regulation were "not [] mere change[s] in procedure, but [] change[s] affecting substantive rights."[29] Accordingly five of the alleged deficiencies cited in the Draft Report are fully in compliance with applicable law.

f. Prevailing Belief as to Repeal of TB Testing Requirement

In addition, contextual considerations should be taken into account when assessing Clovis' compliance with the PCO Regulations. By far the largest category of deficiencies in the Draft Report relate to "Missing Evidence of Tuberculosis Testing." According to the OIG, there are 36 deficiencies relating to TB testing.[30] But there is a simple explanation for many of the deficiencies in this category: Clovis relied on a letter dated July 21, 2004, informing it that "[as] of July 30, 2004, TB testing is no longer a state mandated requirement for employment in health facilities, schools and day care centers." This letter explained that "New Mexico has been a low incidence state for TB since 2000, which means that there are fewer than 3.5 TB cases per 100,000 population. There has been on average a 5% per year decline in TB cases since the 1950s." Clovis understandably believed that the repeal of the tuberculosis testing requirement applied to it because,

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[24] NMAC 8.315.4.5 (2004).

[25] NMAC 8.4.738 (2000).

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

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

[28] NMAC 8.315.4.5 (2004) (underline added).

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

[30] As stated above, Clovis has located and submitted tuberculosis tests pre-dating the dates of service for sample item numbers 19, 20, 34, 37, 42, 57, 83, 90, 91, 96 and 97; and sample item numbers 20, 49, 52, 58 and 96 are inappropriately deemed deficient because the attendants were hired before the tuberculosis testing requirement appeared in the PCO regulations. Accounting for these, there are only 20 remaining tuberculosis testing deficiencies.

among other things, it was sent a copy of this letter by the New Mexico Department of Health ("DOH") on July 23, 2004. In the DOH's letter, it again referred to the "[r]epeal of state-mandated tuberculin screening of low-risk individuals . . ."[31]

Based on these letters, Clovis believed that the requirement for tuberculosis testing had been repealed. To ensure its understanding of the letter was correct, Clovis contacted Joie Glenn, Executive Director of the New Mexico Association for Home and Hospice Care. Ms. Glenn interpreted the DOH letter differently from Clovis, and suggested that Clovis continue TB testing. Intent on following the regulatory requirements, Clovis did as Ms. Glenn advised. Thereafter, however, DOH informed Clovis that it would no longer offer testing of Clovis' attendants. When Clovis inquired as to the reason for this discontinuance, DOH informed Clovis that, per its July 2004 letter, the requirement for TB testing had been repealed, including as to PCO agencies.

Admittedly, despite the repeal of the Department of Health regulation requiring tuberculosis testing in health facilities and other settings in 2004, the Human Services Department's PCO regulations continued to require testing upon initial employment of PCO attendants. But we understand that Clovis was not the only entity confused by this inconsistency and misled by the DOH's correspondence. Likely to address this problem, HSD has revised the PCO Regulations to now require tuberculosis testing only as mandated by the DOH,[32] and as recently as October 24, 2010, issued an additional memorandum to PCO agencies clarifying the concurrent TB testing requirements of the Center for Disease Control. Clovis' alleged deficiencies regarding tuberculosis testing should be evaluated only in the context of the then-common understanding of applicable legal standards and a New Mexico official's statements regarding the repeal of tuberculosis testing requirements.

g. CPR/FA Certifications Within Permissible Window

Of the four CPR/FA certification deficiencies, two of the alleged deficiencies ignore that the attendants did, in fact, have the required certifications within the time frame set forth in the PCO Regulations. The then-applicable 2004 PCO Regulations required that "all attendants . . . must [] complete[] within the first three (3) months of employment . . . cardiopulmonary resuscitation (CPR) and first aid training . . ." and thereafter the "CPR and first aid certifications must be kept current."[33] For sample item numbers 18 and 94, the attendants obtained their CPR/FA certifications within three months of their date of hire, as required by the 2004 PCO Regulations.[34] For sample item number 18, the attendant was hired on October 24, 2008; the dates of service were November 13 to 14, 2008; and the attendant became CPR/FA certified on January 22, 2009. The attendant for

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[31] Copies of both letters are enclosed here.

[32] NMAC 8.315.4.11(B)(31) (2010) (replacing the requirement for tuberculosis testing upon initial employment with a requirement that PCO agencies instead "follow[] current recommendations of the state department of health for preventing the transmission of tuberculosis (TB) for attendants upon initial employment and as needed").

[33] NMAC 8.315.4.11(A)(2)(c)-(d) (2004).

[34] *Id.*

number 18, therefore, became CPR/FA certified 90 days after the date of hire, which is within the three-month window mandated by the 2004 Regulations. Second, for sample item number 94, the attendant was hired on October 14, 2008; the dates of service were December 20 to 22, 2008; and the attendant became CPR/FA certified on January 8, 2009. The attendant for number 94, therefore, became CPR/FA certified 86 days after the date of hire, which again is within the three-month window mandated by the 2004 Regulations. In light of these calculations, the CPR/FA certification deficiencies alleged as to sample item numbers 18 and 94 should be stricken.[35]

h. Additional Factual Considerations as to Supervisory Visits

Certain additional factual considerations exist as to sample item numbers 21 and 87. First, for sample item number 21, additional review of the file indicates that at least an attempted visit was performed in the month at issue, February 2009. This evidence consists of a mileage log entry showing that a trip was made by a supervisor to the client's home on February 18, 2009. While this evidence is not in Clovis' typical form, i.e. a supervisory visit slip, it does indicate that at least an attempted visit to the client's home was performed during the month at issue. Second, as to sample item number 87, a supervisory visit was not performed during the month at issue because the client was not receiving and was not approved for services for 20 days out of the month. Clovis' records show that the client's services ceased in November 2008 and did not re-start until January 21, 2009. It is therefore unsurprising that a supervisory visit did not occur in the remaining 10 days of January after the services re-started. When the services did re-start, Clovis ensured that a supervisory visit was performed within 30 days from the date that the services re-started. That is, Clovis performed a supervisory visit on February 17, 2009, which was 27 days after the services re-started.

i. Unwritten Policies v. Regulations

Under "Other Matter[s]," the OIG disputes $2,404 associated with "25 of the 100 sampled claims" for time spent by attendants in meal preparation and housekeeping services because the attendant and client lived in the same home. The OIG does not specify which 25 claims fall into this category. As a result, Clovis is denied its opportunity to respond substantively to the allegation. Even without knowing to which samples the OIG's complaint relates, it is still clear that the sum identified by the OIG was appropriately paid under the then-applicable PCO Regulations. As the OIG admits in its Draft Report, "there are no Federal or State regulations addressing payment for services provided by an attendant who lives with the recipient . . ." Indeed, under the then-applicable 2004 Regulations, HSD specifically outlined non-covered services but did not include meal preparation or housekeeping services of attendants living with clients as non-covered.[36] Further highlighting the fact that during the audit period there was no such requirement, current

[35] Clovis' extensive efforts to ensure compliance with the CPR/FA certification requirements should also be noted. As Clovis' files demonstrate, it was very active in making sure that its attendants completed the required annual training and that their CPR/FA certifications did not lapse. For example, the file for the attendant in sample item number 95 contains several written notices and handwritten notes of verbal notices to the attendant regarding the upcoming expiration of her certifications. The efforts documented are standard procedure at Clovis, and likely the reason for its high compliance rate in this category.

[36] *See* NMAC 8.315.4.15 (2004).

draft regulations, published on October 8, 2010, only now propose to prohibit the submission of claims for time spent by attendants in meal preparation and housekeeping services when the attendant and client live in the same home.[37] Therefore, there was nothing improper or unreasonable in Clovis' reimbursement for these types of services.

II. Corrective Action Plan

Notwithstanding Clovis' above concerns regarding a number of the Draft Report's conclusions and its recommendations, Clovis has initiated several efforts to ensure that it is in full compliance with the PCO Regulations.[38] First, Clovis has contacted all current attendants to ensure that each has had a TB test or chest x-ray within the last ten years, and that testing or x-ray results are placed into the attendant's file. As a double-check, going forward, Clovis will also conduct a semi-annual internal audit of attendant medical files for negative tuberculosis skin test results or x-ray readings. In addition, Clovis has adopted a new policy requiring all attendants to have TB tests performed and results read within one week of hire, and individuals are notified of this requirement during the application process. An attendant's file will be deemed incomplete until the test results have been completed, and Clovis' Human Resource Director has been charged with ensuring that all new employees have completed the testing.

Second, Clovis is conducting an internal audit of attendant files to ensure that the attendants have current certifications. For future attendants, Clovis has charged its Human Resources Director with ensuring that all new hires have completed their certifications by, among other things, ensuring that they are not placed with a client until they have been scheduled for a CPR/FA course. Clovis' Human Resources Director will also review an internal certification tracking database monthly to ensure that attendants' certifications do not lapse. Clovis will also continue its practice of annually reviewing files to confirm attendants' certifications and notifying attendants, by phone and in writing, if their certifications are due to expire within the year.

Finally, Clovis recently enacted a three-point Corrective Action Plan to ensure a face-to-face supervisory visit is performed for each client without exception. These Corrective Action Plans demonstrate Clovis' commitment to continue its efforts to comply with the PCO Regulations.

III. Conclusion

For the reasons set forth above, Clovis strongly disputes a number of the findings and recommendations contained in the Draft Report and believes the OIG should revise its report accordingly. If you have any further questions or would like any further documentation regarding the Draft Report, please do not hesitate to contact us.

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[37] NMAC 8.315.4.17(C) (*proposed* Oct. 8, 2010).

[38] Copies of the Corrective Action Plans enacted as a part of these efforts are enclosed.

Sincerely,

BANNERMAN & JOHNSON, P.A.

David H. Johnson

- and -

ARENT FOX LLP

per authority for

Linda A. Baumann

Enclosures as noted.
cc: Randie Hatley

APPENDIX E: NEW MEXICO HUMAN SERVICES DEPARTMENT COMMENTS

New Mexico Human Services Department

Susana Martinez, Governor
Sidonie Squier, Secretary

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

February 13, 2012

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

Re: New Mexico Response - Medicaid Personal Care Services Provided by Clovis Homecare, Inc., A-06-09-00117

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-06-09-00117 titled "Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc."

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

Sincerely,

Julie B Weinberg, Director
Medical Assistance Division
New Mexico Human Services Department
Enclosure

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

DC: 4266941-2

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-06-09-00117 on Medicaid Personal Care Services, Clovis Homecare, Inc.

Table of Contents

A. Introduction

In December 2011, the Department of Health and Human Services ("DHHS") Office of Inspector General ("OIG") issued a draft report entitled "Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc." ("Draft Audit") covering claims from October 1, 2008, to March 31, 2009. The Medical Assistance Division ("MAD") of the New Mexico Human Services Department ("HSD") has reviewed the Draft Audit, and collected information from the Coordination of Long Term Services program ("CoLTS") regarding the claims Clovis Homecare, Inc. ("Clovis") submitted. MAD also requested, received, and reviewed documentation from Clovis offered in support of its response to the Draft Audit, and information from the OIG on the amount it recommended recouping for each allegedly deficient claim.

B. Summary of Response

MAD strongly disagrees that the OIG's findings support the recommendation of the Draft Audit that the State return $404,817 in Federal funds received in response to the Clovis claims and paid to the provider. The Draft Audit identifies six categories of "deficiencies" with respect to 100 reviewed claims, selected on a random basis. It concluded that the claims (or portions of claims) affected by these "deficiencies" amounted to $4,714.[1] It then extrapolated this conclusion to the universe of Clovis's claims for the five-month review period, to arrive at the amount of $404,817 in alleged "overpayments" of Federal funds for the full universe of 17,992 Clovis claims during the audit period.

We respectfully disagree with this conclusion. Five of the six categories of "deficiencies," and 23 of the 24 alleged "deficiencies," involved no demonstrated overpayment of any kind. Rather, the findings were only that particular documents were missing from the reviewed file. But the overall evidence produced by the review clearly demonstrates that the underlying personal care services were valid, allowable, and rendered to eligible beneficiaries, notwithstanding the absence of certain documents. Moreover, for the most part, the missing documentation related not to federal requirements but to state requirements. The applicable state law does not require recovery of payments made to providers even if there was a violation of those state requirements.[2] When the State had determined that violations of these requirements have occurred, the Quality Assistance Bureau ("QAB") has a policy and practice of issuing corrective action plans to prevent further violations.[3] For the remaining category, while MAD acknowledges that the findings support a conclusion that there was a single overpayment of

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

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

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

$21.21, they do not support extrapolating that conclusion to the universe of all claims submitted during the five-month review period. Rather than revealing a pattern of misclaiming or any systemic failure on the part of Clovis, the Draft Report identified only one instance in which unsupported units were billed. The OIG's findings concerning unsupported attendant service units are too isolated, and the sole instance in which unsupported units were found clearly an aberration from the provider's normal practices.

Overall, the findings of the Draft Audit reveal a provider that has been highly compliant with applicable requirements. At most, the few and mostly isolated "deficiencies," in significant part reflecting no more that the inability to document every instance of compliance, warrant the State insisting upon a corrective action plan from the provider to assure its compliance with state requirements, its maintenance of complete records, and its careful review of claims to avoid submitting claims for services not eligible for reimbursement. In fact, as detailed in Clovis's response letter, it has already enacted a 3-point corrective action plan to ensure face-to-face supervisory visits are performed for each client and taken corrective actions to ensure future compliance with the tuberculosis testing, and CPR and first aid certification requirements.

In addition, MAD challenges the OIG's findings concerning the specific claims selected for review because Clovis has been able to provide documentation demonstrating that it complied with the applicable laws. For the reasons detailed below, it would be unreasonable for the Federal government to require recoupment of over 11 percent of the Federal funds that Clovis received during the audit period for administering PCO services ($3,638,976).

C. Background

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

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

Although for most of the time period covered by the Draft Audit New Mexico's Medicaid Fiscal Agent for claims payment processing processed all PCO provider bills under a fee-for-service model, on August 1, 2008, the State implemented the CoLTS Managed Care System that covers all primary, acute, and long-term Medicaid and Medicare services, including PCO services. The CoLTS program operates under CMS-authorized, concurrent 1915(b) and (c) Medicaid waivers. Two managed care organizations ("MCOs")—

AMERIGROUP Community Care Inc. and EVERCARE of New Mexico Inc.—have contracts to provide CoLTS services. The State phased-in CoLTS in certain geographic areas over the first year of implementation, and phased in all counties by April 1, 2009.

D. Alleged Clovis Deficiencies

The OIG's Draft Audit concluded that MAD did not always ensure that Clovis's claims for Medicaid PCO services complied with applicable Federal and State requirements. The auditors determined that of the 100 sample claims from October 1, 2008, through March 31, 2009, that were examined, 76 (totaling $21,291) were in full compliance, and 24 (totaling $4,714) were not. The auditors further determined that 1 of the 24 non-compliant claims was partially allowable. The Draft Audit identified 28 alleged deficiencies contained in those 24 claims which fall into the following 6 categories:

- Missing documentation of attendants' completion of tuberculosis testing (20 claims)
- Missing evidence of supervisory visits (4 claims)
- Missing attendants' cardiopulmonary resuscitation ("CPR") and/or first aid certification (1 claim)
- Unsupported attendant service units (1 claim)
- Missing physician's authorization (1 claim)
- Missing prior approval for personal care services provided by a legal guardian or attorney-in-fact (1 claim)

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

We address each of the six categories of "deficiencies" below.

1. Missing Tuberculosis Testing Documentation

Draft Audit Finding: The OIG auditors found that for 20 of the 100 sampled claims Clovis lacked documentation showing that attendants had received a tuberculosis ("TB") skin test or chest x-ray and tested negative for TB, or been appropriately treated before they furnished services to Medicaid recipients, as required by section 8.315.4.11A(37) of the New Mexico Administrative Code ("NMAC"). The claims in question total $3,974.77. The Draft Audit would reject these claims in their entirety.

MAD Response: Federal law does not require attendants to maintain documentation of TB tests, x-rays, and treatment administered to attendants before they furnish services; therefore, there is no justification for withholding federal funds based on a finding that such training was not provided. Even assuming that the State requirement had been violated, State law does not *require* that payments be

[4] The Draft Audit also identified one type of deficiency in Clovis's claims that did not violate either Federal or State law in effect at the time the claims were made: Charging for attendants' meal preparation and housekeeping services when attendants and recipients live in the same home (25 claims).

withheld from providers when the requirement has not been met. In such cases, the QAB issues corrective action plans for violations rather than recouping payments for any services rendered by the attendants for whom TB documentation is missing. Enforcement of a State training requirement by withholding Federal funds, when it is otherwise apparent that eligible services were provided to an eligible recipient in amounts authorized by a service plan, is unwarranted.

In these 20 cases, the record demonstrates that eligible services were provided to eligible recipients in an appropriate setting in accordance with a physician-approved plan of care. This satisfies the Federal requirements for federal financial participation ("FFP"), and the failure to meet a State tuberculosis testing requirement, even if proved, does not justify withholding that FFP. Nor does the lack of records indicate that PCO services were furnished by attendants with TB. In 10 of the cases, Clovis provided documentation showing that the attendants tested negative for TB after the service dates in question and thus did not have TB. The lack of TB testing documentation dating from the attendants' date of hire merely indicates that Clovis had lost or misplaced the records, not that it failed to systematically require attendants to be tested for TB when they were hired.

Clovis has also voluntary undertaken corrective action to ensure future compliance with the State TB testing documentation requirement. It has contacted all current attendants to ensure that each has undergone a TB test or chest x-ray in the past 10 years and has documentation of this in his or her file. As a further check, Clovis will conduct a semi-annual internal audit of attendant medical files to verify that such documentation exists in each attendant file. In addition, new hires are notified during the application process that they must have TB tests performed and read within a week of hire, and Clovis will ensure that attendant files lacking such testing results shall be deemed to be incomplete.

2. Missing Documentation of Supervisory Visits

Draft Audit Finding: The OIG auditors determined that for 4 of the 100 sampled claims Clovis 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 allegedly overpaid portion of the claim in question amounts to $1,028.59. The Draft Audit would reject these claims in their entirety.

MAD Response: Clovis provided monthly attendant supervisor visit forms for the four claims at issue. In each case, the supervisor had completed a form within 30 days of the dates of service; thus, the specific claims in question complied with the monthly supervisor visit requirement.[5]

Moreover, Federal law does not require that providers maintain documentation of monthly attendant supervisor visits in recipients' homes; thus, there is no justification for withholding federal funds based

[5] The fact that Clovis was unable to provide a completed form detailing a face-to-face supervisor visit for certain calendar months in which the beneficiaries at issue in the four claims received PCO services, and thus, that Clovis may be missing documentation for *other claims* for these beneficiaries should not be included in the OIG's findings because those claims were not among the sampled claims. Even if they were, the claims should not be rejected in their entirety but should be decreased in proportion to the percentage of monthly supervisor visit forms Clovis has been unable to provide.

on a finding that such training was not provided. Even assuming that the State requirement had been violated, State law does not require withholding payment from providers when such documentation is missing, and the QAB issues corrective action plans for such violations rather than recouping payments for any services rendered by the attendants in question.

In addition, even if the Draft Report's findings are correct, the lack of documentation of monthly attendant supervisor visits does not demonstrate that these visits did not take place, but that certain forms were misplaced or lost for the cases in question. In one case (sample item no. 4), although a supervisor visit form for a given month in which the beneficiary received services was missing, Clovis provided the supervisor's mileage log for that month which indicates that the supervisor visited the specific beneficiary in that month, indicating that the supervisory visit in fact took place. Clovis's ability to provide such records for 96 of the 100 sampled claims, and even records for several months of service for the beneficiaries in the four cases at issue, shows that it has had a pattern and practice of requiring such documentation.

3. Missing CPR or First Aid Certification

Draft Audit Finding: The OIG auditors determined that in 1 of the 100 sampled claims Clovis could not provide copies of the attendant's CPR or first aid certification as required by section 8.315.4.11A(2)(d) of the NMAC. The amount of the claim in question is $141.40. The Draft Audit would reject this claim in its entirety.

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

Moreover, the existence of the certification in 99 of the 100 case files reviewed demonstrates that the provider uniformly required that certification to be obtained. Even in the case in question, Clovis provided documentation showing that it discovered that the attendant's CPR and first aid certification was lapsing and made numerous good faith efforts to contacted the attendant to renew this certification; the attendant completed this process within 6 months of the service dates. Far from indicating that Clovis systematically fails to comply with the CPR and first aid certification requirement, this case is an isolated case in which Clovis was not able to ensure that the provider renewed the certification in time.

Clovis has also taken substantial corrective actions to prevent future violations of the State certification requirement. It has voluntarily conducted an internal audit of attendant audit to verify that attendants have current certifications, and continues to annually review files to determine whether certifications have been completed. Clovis has instructed its Human Resources Director to not place new hires with beneficiaries until they have been scheduled for a CPR or first aid course, and to review the internal certification tracking database monthly to ensure that attendants' certifications do not lapse. Attendants whose certifications are due to expire within the year will be notified by phone and in writing.

4. Unsupported Attendant Service Units

Draft Audit Finding: The OIG determined that for 1 of the 100 sampled claims Clovis failed to provide documentation supporting the number of units claimed for attendant services. The OIG did not identify the portion of this single claim which is allegedly deficient for unsupported attendant service units. Because the same sample claim is alleged to have missing physician authorization, the OIG recommends withholding the entire amount of this claim, $162.61.

MAD Response: MAD determined that in the months preceding the time period in which the services provided in the sole claim at issue, the State had reduced the number of allowable household services to 3.5 hours per week. MAD asked Clovis to reexamine approved claims covering the week in which the allegedly deficient claim's underlying services were provided. Clovis informed MAD that 1.5 hours were erroneously allotted during this week. MAD has concluded that Clovis was overpaid $21.21 for the 1.5 hours of overbilled services. MAD notes, however, that this overbilling is, at most, an isolated occurrence at Clovis and the amount of the overpayment is only a minute percentage—less than 0.6 percent—of the total PCO claims reviewed ($26,005), and a result of Clovis adjusting over to the State's new weekly cap on allowable household services.

5. Missing Physician Authorization

Draft Audit Finding: The OIG auditors found that for 1 of the 100 sampled claims Clovis did not have records demonstrating that the recipient had obtained prior physician authorization for the furnished services, as required by 42 C.F.R. § 440.167 and section 8.315.4.16A(1) of the NMAC. The amount of the claim in question is $162.61. The Draft Audit would reject this claim in its entirety.

MAD Response: Clovis produced a physician authorization form (for which the copy lacked an authorization signature for the U.R. contractor) and an extension of authorization letter for the 1 case, the latter of which authorized services on the dates services were actually furnished. Rather than demonstrating that Clovis failed to obtain physician authorization for the services in question, the far more reasonable conclusion from these facts is that the original physician authorization form containing the U.R. contractor authorization was lost or misplaced.

The single claim at issue does not have the deficiency identified in the Draft Report: The *physician* in question authorized the rendered services. Moreover, the *U.R. contractor*, a third party, had the duty of signing off on the physician authorization sheet. In addition, there is no basis upon which to conclude that Clovis has a systemic problem of not obtaining or keeping records of physician authorizations or UR contractor sign-offs. The requisite forms were apparently found in the other 99 case records reviewed. The existence of the necessary documentation in 99 of the 100 sampled cases is powerful evidence that Clovis'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.

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

Draft Audit Finding: The Draft Audit determined that for 1 of the 100 sampled claims Clovis did not provide evidence that MAD issued prior approval for personal care services provided by the recipient's

legal guardian or attorney-in-fact, as required by section 8.315.4.11A (21) of the NMAC. The amount of the allegedly deficient claim is $141.40. The Draft Audit would reject this claim in its entirety.

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

The fact that there is only one case of the 100 sampled cases in which prior approval of legal guardian or attorney-in-fact services is alleged to be missing demonstrates that Clovis uniformly requires that such prior approval be obtained and documented.

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

7. Other PCO Matters

Draft Audit Finding: The OIG auditors found that for 25 of the sampled claims Clovis charged a total of $2,404 in attendants' meal preparation and housekeeping services even though the attendants and recipients lived in the same home. The OIG determined that at the time, such claims did not violate Federal or State law; however, the State has since amended sections 8.315.4.16 and 8.315.3.17 of the NMAC to prohibit such claims.

MAD Response: MAD concurs that the claims for meal preparation and housekeeping services provided by an attendant living in the recipient's home did not violate Federal or State law in effect during the time period covered by the Draft Audit.

E. State Policy Changes and Compliance Measures

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

The State's efforts at improved performance are continuing. It has begun planning for an evidence-based program monitoring system that will enhance the quality of PCO services. In addition, it is

exploring the implementation of a telephonic and GPS tracking system, like that used in other states, to allow for automatic generation of PCO provider timesheet entries. There is a $2 million cost associated with this enhancement.

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

F. Response to Proposed Overpayment Recovery

After calculating that 24 claims or portions of claims derived from the sample resulted in overpayments of $4,714, the Draft Audit used "statistical software" to extrapolate the total refund due to the Federal Government to be $404,817 in FFP for alleged unallowable PCO service claims by Clovis from October 1, 2008 through March 31, 2009. The State takes strong exception to this conclusion.

As shown above, there is no justification for recovery of any Federal funds, with or without extrapolation, with regard to 23 of the 24 questioned claims, which represent all of the $4,714 identified as overpayments by the Draft Audit.[6] For these claims, the findings of the Draft Audit do not support a conclusion that payments were improperly made. Rather, they show that only a minute number of files are missing a document that would confirm the satisfaction of a particular requirement. The overwhelming demonstration in the 100 sample case records of compliance with the requirements in question (compliance in 99% cases for securing CPR and first aid certification, physician authorization, approval for legal guardian service delivery, and compliance in 96% of cases for providing evidence of monthly supervisory visits) negates any conclusion of non-compliance in the few instances in which a document was missing from a file.

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

As to the portions of the Draft Audit relating to excessive billing, the findings reveal no pattern or practice of non-compliance by Clovis. To the contrary, the OIG auditors identified only one instance of overbilling. Even if the Draft Audit's findings are correct, only $21.21 of the total of $26,005 in PCO

[6] The Draft Audit concluded that 4 of the sampled claims each had 2 types of "deficiencies": 2 claims had missing evidence of TB testing and supervisory visits, another had missing evidence of CPR or first aid certification and prior State approval of PCO services provided by a legal guardian or attorney-in-fact, and a final claim had unsupported units of payment and missing evidence of prior physician authorization. In the last instance, the Draft Audit used the larger of the "deficiency" amounts (entirety of the claim for missing prior physician authorization form) in calculating the total Federal share of the 23 "deficient" claims.

claims reviewed in the audit represented amounts claims in excess of the time reflected on the timesheets or that was authorized by the service plan. This would mean that Clovis's error rate is only 0.08 percent, far less than the tolerance levels established in various quality control programs in Medicaid and other federal funded programs. *See, e.g.,* 42 C.F.R. § 431.865 (establishing a 3% tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program; 45 C.F.R. §205.42 (1980) (establishing a 4% tolerance limit for payment errors in the Aid to Families with Dependent Children program). In these programs, it is standard federal policy, when overall performance is within the established tolerance limits, to seek recoveries only for specific overpayments actually identified, and not to extrapolate the results of a review to the caseload as a whole. That policy should be applied in this case, where the level of erroneous payments is as low as it is.

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

G. Conclusion

The results of the OIG investigation, reflected in the Draft Audit, are encouraging to MAD, for they demonstrate an extremely high level of compliance by Clovis. While there is always room for improvement and the State intends to continue its long standing efforts to enhance performance of its PCO providers, the results of the Federal review should provide comfort to Federal officials that Federal funds are being properly spent in the case of Clovis's PCO services. The State would be prepared to repay $16.38,[7] the federal share associated with the sole instance of overbilling.

[7] This amount was calculated by applying the FMAP rate for Federal Fiscal Year 2009 of 77.24 percent to the sample case overpayment of $162.61.

Appendix: State Policy Changes and Compliance Measures

1. Overall PCO Improvements

(a) Regulation Changes

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

September 15, 2010 PCO Regulation Changes:

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

December 30, 2010 PCO Regulation Changes:

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

September 15, 2011 PCO Regulation Changes:

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

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

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

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

(b) PCO Billing and Administrative Workgroup

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Corrective Measures Relating to Clovis Deficiencies

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

(a) TB Testing

Beginning in 2009, the training required of new PCO providers has emphasized the importance of compliance with the TB testing requirement. Effective December 2010, MAD's revised the underlying PCO regulations setting forth the requirement in accordance with 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 have been posted on the ALTSD and MAD websites to further reinforce this regulatory requirement and provide guidance on the process. The posted documents include the require TB testing form and contact information for the NMDOH TB program.

Each CoLTS MCO—Evercare and Amerigroup—provides 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 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.

- 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.

MAD also emails updates on PCO compliance issues to all PCO providers. These emails are copied 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.

(b) 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 (a), 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.

(c) 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.

Beginning in 2009, the training required of new PCO providers took care to emphasize the importance of compliance with the requirement for CPR certification. Technical assistance documents provided at the trainings were posted on the ALTSD and MAD websites to further reinforce this regulatory requirement. As detailed above in the discussion of corrective strategies relating to the TB testing requirement, the State continues to provide training materials and technical assistance to PCO agencies to improve regulatory compliance.

As detailed above in (a), each CoLTS MCO provides PCO agencies with continuing education regarding 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.

(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. 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. The amount of hours scheduled on the IPoC must match the total number of authorized hours on the authorization. The type of services on the IPoC must match the services authorized by the MCO. The timesheet must match the hours and services on the IPoC.

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

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

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

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

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

As detailed above in (a), 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. One of the required content areas will be ensuring timesheet accuracy in accordance with the IPoC.

(e) 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.

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

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

The MCO Service Coordinators assist in assuring compliance with the prior approval for paid legal representatives requirement. If the Service Coordinator discovers a legal representative acting in the role of the paid attendant without obtaining prior state approval, he/she will alert the PCO agency. In

addition, if a beneficiary communicates to the Service Coordinator either at the time of assessment or by calling the Customer Service Line that he or she wishes to employ their legal representative as his or her paid attendant, the Service Coordinator contacts the PCO agency, on the beneficiary's behalf, to facilitate the process. The request is documented in the beneficiary's file.

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.