



October 29, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Joe J. Green/ for
George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia (A-03-08-00207)

Attached, for your information, is an advance copy of our final report on personal care services provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia. We will issue this report to the District of Columbia's Department of Health Care Finance 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 Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-08-00207.

Attachment



Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

November 4, 2010

Report Number: A-03-08-00207

Julie Hudman, Ph.D.
Director
Department of Health Care Finance
825 North Capitol Street NE, Suite 500
Washington, DC 20001

Dear Dr. Hudman:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia*. 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, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through email at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-08-00207 in all correspondence.

Sincerely,

/Stephen Virbitsky/
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
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Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PERSONAL CARE SERVICES
PROVIDED BY TRI-STATE HOME HEALTH
AND EQUIPMENT SERVICES, INC., IN THE
DISTRICT OF COLUMBIA**



Daniel R. Levinson
Inspector General

November 2010
A-03-08-00207

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 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 the District of Columbia (District), the Department of Health Care Finance (State agency) administers the Medicaid program.

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to beneficiaries in their homes and may not be provided in an institutional setting. In the District, personal care services are prescribed by a physician or advanced practice registered nurse in accordance with a plan of care and provided by qualified personal care aides (PCA) under the supervision of a registered nurse.

Attachment 3.1-A of the District's Medicaid State plan authorizes personal care services, which provide assistance with activities of daily living including bathing, grooming, and eating. During our audit period, the State plan limited personal care services to no more than 8 hours per day and 1,040 hours during any 12-month period. These limits could be exceeded if preauthorized by the State agency. The District also provides personal care services through a section 1915(c) waiver, *Home and Community-Based Waiver for the Elderly and Individuals With Physical Disabilities* (waiver). The waiver allows up to 16 hours of services per day.

Tri-State Home Health and Equipment Services, Inc. (Tri-State), a residential service agency, received \$16,538,233 (\$11,576,763 Federal share) in Medicaid payments for personal care services provided to 518 beneficiaries in the District from July 1, 2006, through September 30, 2007. During this period, Tri-State was the District's largest provider of personal care services.

OBJECTIVES

Our objectives were to determine whether the State agency:

- paid Tri-State only for personal care service claims that complied with the State plan or waiver requirements for allowable hours of service and only for services actually provided and
- ensured that PCAs met District qualification requirements.

SUMMARY OF FINDINGS

The State agency paid Tri-State for personal care services that did not always comply with the State plan or waiver requirements for allowable hours of service and for personal care services

that were not always provided. Payments for services to 326 beneficiaries were sufficiently documented, including services for all the 155 beneficiaries for whom Tri-State requested and received approval under the State agency's waiver. However, the State agency made payments, totaling \$1,595,422 (\$1,116,796 Federal share), for unallowable services to 148 beneficiaries:

- \$1,588,315 (\$1,111,821 Federal share) on behalf of 134 beneficiaries for whom Tri-State claimed hours of service in excess of the State plan limit but did not provide documentation that it requested or received the required authorization for the extended service and
- \$7,107 (\$4,975 Federal share) on behalf of 14 beneficiaries for whom Tri-State claimed hours of services that were not provided.

We set aside for CMS's adjudication \$1,153,897 (\$807,728 Federal share) paid on behalf of an additional 44 beneficiaries for whom Tri-State claimed hours of service under the waiver. Tri-State documented that it had submitted requests for waiver services for these beneficiaries but did not have evidence to support that it had received preauthorization for services under the waiver. We also determined that the State agency did not ensure that all Tri-State's PCAs met the District's qualification requirements. Of the 110 PCAs who provided services to the 86 beneficiaries we reviewed for quality of care, 13 did not meet one or more of the District's qualification requirements.

These errors occurred because the State agency lacked sufficient controls to identify and review claims that exceeded authorized limits and because Tri-State lacked sufficient controls to ensure that it obtained and documented receipt of State agency authorizations needed to justify Tri-State's claims.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$1,111,821 (Federal share) for claims in excess of State plan limits paid without documentation of the required authorization,
- refund \$4,975 (Federal share) for claims paid for services that were not provided,
- work with CMS to determine the allowability of \$807,728 (Federal share) paid for waiver claims for which preauthorization of services was not adequately supported,
- implement prepayment controls to monitor personal care services claims for compliance with Federal and District requirements, and
- provide more effective monitoring of PCA compliance with qualification requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the action it has taken, or plans to take, to address them. The State agency said that it had implemented prepayment controls and PCA monitoring procedures. As part of its PCA monitoring, the State agency also requested documentation of our interviews with Tri-State clients.

The State agency's comments are presented in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

The Medicaid Program

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 Medicaid 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 the District of Columbia (District), the Department of Health Care Finance (State agency) administers the Medicaid program.

The District's Personal Care Services Program

The District's personal care services program is operated by the State agency's Office of Disabilities and Aging, which is responsible for authorizing personal care services and monitoring the personal care services program. Personal care services include, but are not limited to, bathing, grooming, and assistance with toileting or bed pan use; meal preparation in accordance with dietary guidelines and assistance with eating; and shopping for items related to promoting the patient's nutritional status and other health needs.

Supplement 1 to Attachment 3.1-A of the District's Medicaid State plan authorizes personal care services, prescribed in accordance with a plan of care and furnished by a qualified person under supervision of a registered nurse. The District's section 1915(c) waiver, *Home and Community-Based Waiver for the Elderly and Individuals With Physical Disabilities* (waiver) allows a more intensive level of personal care services for beneficiaries eligible for nursing home care.

Federal Requirements Related to Personal Care Services

The State agency must comply with certain Federal requirements in determining and redetermining whether beneficiaries 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 must be (1) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a legally responsible family member; and (3) furnished in a home or, at the State's option, in another location.

State Plan Requirements Related to Personal Care Services

Pursuant to the State plan and District Municipal Regulations (DCMR), a personal care aide (PCA), under the supervision of a registered nurse, provides beneficiaries' personal care services.¹ Qualified family members, who are not the beneficiary's spouse, parent, or other legally responsible relative, may also provide personal care services. Effective September 2003, the State agency's reimbursement fee schedule set personal care services at \$16.30 per hour. During our audit period, the State plan limited reimbursement for personal care services to no more than 8 hours per day and 1,040 hours during any 12-month period. These limits could be exceeded if prior authorization was given by the State agency.²

District regulations (29 DCMR § 5007.8) require providers to maintain records of initial and annual assessments; plans of care and recertifications of plans of care; description and dates of services rendered, including the name of the PCA performing the services; supervisory visits of the registered nurse, including signed and dated clinical progress notes; discharge summaries; and authorizations for extending the period of service.

The District's Home and Community-Based Waiver for the Elderly and Individuals With Physical Disabilities

Section 1915(c) of the Act permits States to seek a waiver from its State plan to furnish an array of services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver costs must be "cost neutral," meaning they may not exceed the cost of institutionalization (section 1915(c)(2)(D) of the Act). The District's section 1915(c) waiver authorizes nursing-home-level services, including case management, personal care, and respite care, delivered in the home or in an assisted living facility in lieu of a nursing home. The waiver allows up to 16 hours of service per day with no limit on total cumulative services for approved beneficiaries.

District regulations set forth the requirements for personal care waiver services (29 DCMR chapter 42, "Home and Community-Based Waiver Services for Persons Who Are Elderly and Individuals With Physical Disabilities"). Services under the waiver must be approved by the State agency. District regulations state that "[e]ach provider of waiver services shall receive approval from the case manager prior to initiating, changing, adding, or terminating any approved waiver service" (29 DCMR § 4203). The case manager must submit the necessary documentation, including a comprehensive assessment and a plan of care, to the State agency's representative, who disapproves services or preauthorizes approved services (waiver, Appendix D-2: 3). District regulations implementing the waiver require, among other things, that the case manager submit to the State agency the necessary documentation for review and approval of waiver services (29 DCMR § 4216.8).

¹ Supplement 1 to Attachment 3.1A, sections 24.F.3 and 4, page 29, and 29 DCMR §§ 5002.5(c), 5003.1, and 5004.3.

² Supplement 1 to Attachment 3.1A, sections 24.F.1, page 29.

Tri-State Home Health and Equipment Services, Inc.

Tri-State Home Health and Equipment Services, Inc. (Tri-State), was founded in 1992 as a residential service agency in Maryland. Tri-State provides personal care services, home health services, and medical equipment rentals in the District and four Maryland counties. During our audit period, Tri-State was the District's largest provider of personal care services. For each beneficiary receiving services from PCAs, Tri-State maintained paper files of required records, including timesheets identifying hours and services performed.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency:

- paid Tri-State only for personal care service claims that complied with the State plan or waiver requirements for allowable hours of service and only for services actually provided and
- ensured that PCAs met District qualification requirements.

Scope

Our audit period covered July 1, 2006, through September 30, 2007. We reviewed a database of 138,642 claims submitted by Tri-State for personal care services provided to 518 Medicaid beneficiaries, for which the State agency made payments totaling \$16,538,233 (\$11,576,763 Federal share). We did not determine the validity of the plans of care or the accuracy of the timesheets documenting the services provided by the PCAs.

During our audit, we did not review the overall internal control structure of the District or the Medicaid program. Rather, we limited our internal control review to the controls related to the objective of our audit.

We conducted fieldwork at the State agency and Tri-State's office in the District. Our fieldwork also included visits to residences of 49 recipients of personal care services.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and the State plan;
- held discussions with State agency officials and reviewed applicable policies and procedures to gain an understanding of the personal care services program;

- reconciled a database of paid claims for personal care services to amounts claimed by the State agency on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program;
- reviewed a State agency database containing a record of institutional services provided to those of the 518 Medicaid beneficiaries who received the services from July 1, 2006, through September 30, 2007;
- compared the database of personal care services with the database of institutional services to identify duplicate dates of service;
- reviewed hospital admission and discharge documentation to confirm dates for institutional services;
- reviewed Tri-State’s client case records for each of the 518 Medicaid beneficiaries to determine whether the State agency authorized services consistent with the State plan requirements;
- selected, from the database of Tri-State’s 138,642 claims, a simple random sample of 100 claims for personal care services provided to 86 beneficiaries and:
 - visited and interviewed 49 beneficiaries associated with the claims or their family members, if available,³ to determine whether concerns existed regarding any PCA who had provided care to them or regarding Tri-State in general and
 - reviewed supporting documentation to determine whether PCAs met the minimum standard qualification requirements to provide the necessary level of care under the State plan; and
- discussed our findings with Tri-State but did not solicit written comments.

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 objectives.

FINDINGS AND RECOMMENDATIONS

The State agency paid Tri-State for personal care services that did not always comply with the State plan or waiver requirements for allowable hours of service and for personal care services that were not always provided. Payments for services to 326 beneficiaries were sufficiently

³ Twenty-three beneficiaries did not respond to phone contacts or home visits, five beneficiaries were deceased, three beneficiaries were hospital inpatients, three beneficiaries no longer resided at the address of record, two beneficiaries refused to share any of their concerns, and one beneficiary was located but was incoherent.

documented, including services for all the 155 beneficiaries for whom Tri-State requested and received approval under the State agency's waiver. However, the State agency made payments, totaling \$1,595,422 (\$1,116,796 Federal share), for unallowable services to 148 beneficiaries:

- \$1,588,315 (\$1,111,821 Federal share) on behalf of 134 beneficiaries for whom Tri-State claimed hours of service in excess of the State plan limit but did not provide documentation that it requested or received the required authorization for the extended service and
- \$7,107 (\$4,975 Federal share) on behalf of 14 beneficiaries for whom Tri-State claimed hours of service that were not provided.

We set aside for CMS's adjudication \$1,153,897 (\$807,728 Federal share) paid on behalf of an additional 44 beneficiaries for whom Tri-State claimed hours of service under the waiver. Tri-State documented that it had submitted requests for waiver services for these beneficiaries but did not have evidence to support that it had received preauthorization for services under the waiver.

We also determined that the State agency did not ensure that all Tri-State's PCAs met the District's qualification requirements. Of the 110 PCAs who provided services to the 86 beneficiaries we reviewed for quality of care, 13 did not meet one or more the of the District's qualification requirements.⁴

These errors occurred because the State agency lacked sufficient controls to identify and review claims that exceeded authorized limits. Tri-State also lacked sufficient controls to ensure that it obtained and documented receipt of State agency authorizations needed to justify Tri-State's claims.

FEDERAL AND STATE AGENCY DOCUMENTATION REQUIREMENTS

Section 1902(a)(27) of the Act requires that providers enter into agreements with the State agency to provide services under the State plan. Providers must agree "(A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request" Section 2497.1 of the *State Medicaid Manual*, CMS Pub. No. 45, provides for Federal financial participation for those claims with "adequate supporting documentation in readily reviewable form."

District regulations require that each patient's record shall include, among other documents, "[d]escription and dates of services rendered, including the name of the personal care aide performing the services" and "[e]xtended authorizations for services" (29 DCMR § 5007.8).

⁴ We questioned the payments for most of the services provided by these PCAs on the basis of the hours claimed.

Subsequent to our fieldwork, the State agency issued a reminder to providers and also revised its billing controls.⁵

District waiver regulations require that providers must maintain comprehensive beneficiary records for 6 years (29 DCMR § 4205.3). The records must contain documentation of the approved plan of care and preauthorizations for services, as well as “any other records necessary to demonstrate compliance with all rules, regulations, requirements, guidelines, and standards for the implementation and administration of this waiver” (29 DCMR § 4205.4).

PRIOR AUTHORIZATION NOT DOCUMENTED

The District’s State plan limited PCA services to a maximum of 8 hours per day, up to 1,040 hours in any 12-month period.⁶ However, the State agency may provide prior authorization for services in excess of State plan limits.

The State agency paid \$1,588,315 (\$1,111,821 Federal share) on behalf of 134 beneficiaries for whom Tri-State claimed hours of service in excess of the State plan limit without documentation that Tri-State had requested or received the required prior authorization. For one beneficiary, Tri-State had no documentation that any services had been provided. For the remaining 133 beneficiaries, Tri-State provided us with the document it used to track service hours and identify when a beneficiary reached the State plan limit of 1,040 hours during any 12-month period. However, Tri-State continued to claim hours of service after the State plan limit had been exceeded. Tri-State provided no documentation to indicate that it requested or that the State agency granted authorization for the excess services. For example, in one 12-month period, a beneficiary received 3,390 hours of service instead of the allowable 1,040 hours of service. Although the beneficiary’s plan of care required hours of service in excess of the State plan limits, Tri-State neither requested nor received authorization for the extended 2,350 hours of services, and therefore, the State agency overpaid \$38,305 (\$26,814 Federal share).

SERVICES NOT PERFORMED

The State plan allows services furnished by qualified persons under the supervision of a registered nurse.⁷ Providers must maintain records as required in 29 DCMR § 5007.8. Services that are not furnished would not be covered under the State plan. Federal and District regulations (42 CFR § 440.167(a) and 29 DCMR § 5004.8) prohibit personal care services “in a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease”

⁵ *Billing and Prior Authorization of Personal Care Services*, DHCF Transmittal No. 10-01, January 6, 2010.

⁶ Supplement 1 to Attachment 3.1A, section 24.F.1, page 29, as implemented in 29 DCMR § 5009.2. To simplify recordkeeping, DHCF Transmittal No. 10-01 (Jan. 6, 2010), modified the 12-month period for State plan limits to the calendar year.

⁷ Supplement 1 to Attachment 3.1A, section 24.F.1, page 29.

The State agency paid \$7,107 (\$4,975 Federal share) on behalf of 14 beneficiaries for whom Tri-State claimed personal care services that were not provided. The services were scheduled but not provided because the beneficiaries were receiving inpatient Medicaid services at acute-care hospitals during the claimed period. For example, one beneficiary was hospitalized from July 9 through August 15, 2006. Tri-State claimed 8 hours of personal care services per day from July 9 through August 4, 2006 (21 of the 38 hospital days). We allowed claims for personal care services on the admission date but questioned the remaining payment of \$2,608 (\$1,826 Federal share) for the other 20 days.

APPROVAL OF WAIVER SERVICES NOT DOCUMENTED

Services under the waiver must be approved by the State agency. District regulations state that “[e]ach provider of waiver services shall receive approval from the case manager prior to initiating, changing, adding, or terminating any approved waiver service” (29 DCMR § 4203). The case manager must submit the necessary documentation, including a comprehensive assessment and a plan of care, to the State agency’s representative, who disapproves services or preauthorizes approved services (waiver, Appendix D-2: 3). District regulations implementing the waiver require, among other things, that the case manager submit to the State agency the necessary documentation for review and approval of waiver services (29 DCMR § 4216.8). The case manager must use the uniform documentation forms as provided and directed by the State agency (29 DCMR § 4218.2).

We set aside for CMS’s adjudication \$1,153,897 (\$807,728 Federal share) paid on behalf of 44 beneficiaries for whom the State agency paid for hours of services that Tri-State claimed under the waiver. Tri-State documented that it had properly submitted requests for waiver services for these beneficiaries and that it had documented that the beneficiaries were eligible for nursing home care. However, neither Tri-State nor the State agency provided evidence to support that the beneficiary had received the required preauthorization for waiver services.⁸

CAUSE OF UNALLOWABLE CLAIMS

These errors occurred because the State agency lacked sufficient controls to identify and review claims that exceeded authorized limits. Also, State agency officials said that the State agency had a backlog of requests for waiver services. Likewise, Tri-State lacked sufficient controls to ensure that it obtained and documented receipt of State agency authorizations needed to justify the personal care services claims.

PERSONAL CARE AIDES LACKED QUALIFICATIONS

District regulations (29 DCMR §§ 4221.1 and 5003.2) establish qualifications that each PCA must meet, including training, cardiopulmonary resuscitation certification, and knowledge of emergency and infection control procedures; freedom from communicable disease; and

⁸ Tri-State received State agency approval for Waiver services for 155 beneficiaries.

documentation of acceptance or rejection of the hepatitis vaccine. PCAs must also pass a criminal background check pursuant to 29 DCMR §§ 4221.1(j) and 5003.2(n).

We reviewed personnel files for 110 PCAs associated with the 86 beneficiaries that we reviewed for quality of care and identified shortcomings in the qualifications of 13 PCAs. The table below identifies the number of PCAs for whom each shortcoming applied. The total exceeds 13 because we identified multiple deficiencies for four PCAs.

Qualification Shortcomings Identified in Personal Care Aides Personnel Files

Qualification Shortcoming	Number of PCAs
Freedom from communicable disease not documented	4
Hepatitis vaccine not documented ⁹	4
Required 75 hours of classroom training not documented	3
No current cardiopulmonary resuscitation certification	3
Required 12 hours of annual continuing education not documented	2
Out-of-date criminal background check	1

Because the State agency did not sufficiently monitor Tri-State’s compliance with qualification requirements, PCAs who did not meet District qualification requirements were permitted to provide care to beneficiaries. As a result, quality of care to beneficiaries may have been compromised.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$1,111,821 (Federal share) for claims in excess of State plan limits paid without documentation of the required authorization,
- refund \$4,975 (Federal share) for claims paid for services that were not provided,
- work with CMS to determine the allowability of \$807,728 (Federal share) paid for waiver claims for which preauthorization of services was not adequately supported,
- implement prepayment controls to monitor personal care services claims for compliance with Federal and District requirements, and
- provide more effective monitoring of PCA compliance with qualification requirements.

⁹ Tri-State had no documentation to support that the four PCAs had received, or been offered and declined, the hepatitis vaccine.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the action it has taken, or plans to take, to address them. The State agency said that it had implemented prepayment controls and PCA monitoring procedures. As part of its PCA monitoring, the State agency also requested documentation of our interviews with Tri-State clients.

The State agency's comments are presented in their entirety as the Appendix.

OTHER MATTERS: BENEFICIARY-IDENTIFIED PROBLEMS WITH PERSONAL CARE SERVICES

We randomly sampled 100 claims that Tri-State submitted for personal care services to 86 beneficiaries. We then interviewed 49 of the 86 beneficiaries or their family members to determine whether quality-of-care issues existed with the PCA in particular or with Tri-State in general. We did not interview the remaining 37 sampled beneficiaries because they did not respond to our request or we could not locate them. Of the 49 beneficiaries interviewed, 23 identified problems with the personal care service benefit. For example, we interviewed beneficiaries and their families who described PCAs who arrived late or failed to show up for duty, did not follow the plan of care, or neglected the beneficiary in a way that resulted in physical harm. We were unable to determine if any of the identified problems occurred on the specific service date drawn in our sample. For some beneficiaries, we were able to determine that the problems identified occurred during our audit period. However, not all of the identified problems occurred during our audit period. We are providing the State agency with detailed information on the identified problems.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

September 22, 2010

Steven Virbitsky
Regional Inspector General for Audit Services
Office of the Inspector General
US Department of Health and Human Services
Office of Audit services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall west
Philadelphia, PA 19106-3499

Dear Mr. Virbitsky:

This letter responds to the findings contained in your Office's draft report, *Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia* (report number A-03-08-00207). This report sets forth findings of your Office's review of claims submitted by Tri-State Home Health and Equipment Services, Inc., for the period July 1, 2006 through September 30, 2007. This review found that:

1. The State agency paid Tri-State for personal care services that did not always comply with the State plan or waiver requirements and for personal care services that were not always provided. These payments totaled \$1,595,422 (\$1,116,796 Federal share), including:

\$1,588,315 (\$1,111,821 Federal share) on behalf of 134 beneficiaries for whom Tri-State claimed hours of service in excess of the State plan limit but did not provide documentation that it requested or received the required authorization for the extended service and \$7,107 (\$4,975 Federal share) on behalf of 14 beneficiaries for whom Tri-State claimed hours of service that were not provided.

2. In addition, your audit questioned \$1,153,897 (\$807,728 Federal share) paid on behalf of an additional 44 beneficiaries for whom Tri-State claimed hours of service under the District's section 1915(c) Home and Community-Based Waiver for the Elderly and Individuals With Physical Disabilities waiver.

3. The audit also found that some Tri-State Personal Care Aides (PCAs) did not meet the District's qualifications requirements.

Steven Virbitsky
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The audit concluded that these errors occurred because the State agency lacked sufficient controls to identify and review claims that exceeded authorized limits and that Tri-State also lacked sufficient controls to ensure that it obtained and documented receipt of State agency authorizations needed to justify Tri-State's claims. Your Office has recommended that the Department of Health Care Finance:

1. Refund \$1,111,821 (Federal share) for claims in excess of State plan limits paid without documentation of the required authorization,
2. Refund \$4,975 (Federal share) for claims paid for services that were not provided,
3. work with CMS to determine the allowability of \$807,728 (Federal share) paid for waiver claims for which preauthorization of services was not adequately supported,
4. Implement prepayment controls to monitor personal care services claims for compliance with Federal and District requirements, and
5. Provide more effective monitoring of PCA compliance with qualification requirements.

We concur with each of the above recommendations and will refund the amounts specified in your first two recommendations. We will also work with CMS to determine the allowability of \$807,728 (Federal share) paid for waiver claims for which preauthorization of services was not adequately supported.

With respect to recommendations four and five, we have already undertaken a number of actions subsequent to the period covered by this review that help to more effectively monitor personal care services claims for compliance with Federal and District requirement and provide more effective monitoring of PCA compliance with qualification requirements. We also have additional actions underway. These are detailed below.

DHCF actions to more effectively monitor personal care services claims for compliance with Federal and District requirement:

- In July 2010, DHCF transferred the PCA prior authorization process to the District's Quality Improvement Organization (QIO), Delmarva Foundation, to ensure more consistent monitoring.
- Additionally, in 2011, the District will implement a hard cap of 520 hours per year of PCA and will prior authorize from the first request for services.
- Finally, DHCF is drafting more rigorous regulations for PCA services that contain a number of safeguards that will enable more effective abuse prevention and monitoring.

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DHCF actions to provide more effective monitoring of PCA compliance with qualification requirements:

During the time period of the OIG review, the District of Columbia did not have licensure for home health agencies or personnel requirements for home care agencies. In 2009, the District implemented licensure requirements for home health agencies (DCMR Title 22, Chapter 31).

Compliance monitoring is undertaken by the District's Health Regulations and Licensing Administration. Additionally, in DCMR Title 22, Chapter 39, Section 3907, the District now sets forth requirements for home care agency personnel including credentialing and training.

In addition, your report states that it detected other beneficiary-identified problems through interviews with beneficiaries or their family members. The report states that your Office will provide us with detailed information on the identified problems. We are eager to receive this information.

Please contact Ms. Ann Page, Director of the DHCF's Health Care Accountability Administration if you have any questions about this report. She can be reached at 202-478-5792 or ann.page@dc.gov.

Sincerely,

A handwritten signature in black ink, appearing to be 'JH', with a long horizontal stroke extending to the right.

Julie Hudman, Ph.D.
Director
Department of Health Care Finance