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Missouri State Auditor

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Missouri State Auditor

YELLOW SHEET

Additional efforts are needed to identify and collect overpayments and opportunities exist to further standardize authorized services

The state spent approximately $233 million during fiscal year 2005 for home and community-based personal care services provided to Medicaid eligible elderly and disabled individuals. We focused audit efforts on determining (1) whether improvements are needed in the Department of Heath and Senior Services' (DHSS) ability to detect and recoup improper program payments to providers, and (2) the status of recommendations addressed in our 2004 report titled "Medicaid Personal Care Services Program" (Report No. 2004-02).

Recoupment of overpayments limited

During fiscal year 2005, Department of Social Services, Division of Medical Services (DMS) personnel initiated recoupment of approximately $503,000 in program funds, primarily as the result of quality assurance (QA) provider reviews. However, recoupment of Medicaid funds amounted to only .2 percent of $233 million in program expenditures for fiscal year 2005. In 2001, the U.S. Government Accountability Office reported Illinois, Texas, and Kansas identified improper payment error rates of 4.7 percent, 7.2 percent, and 24 percent, respectively. An assumed error rate of 1 percent would equal $2.3 million in improper program payments. (See pages 9 and 18)

Efforts to detect overbilling limited and not timely

DHSS has relied on its QA process and hotline complaints to detect provider overbilling. However, QA's review process provided less assurance overbilling would be detected because QA's responsibilities to detect overbilling had not been clearly defined, and reviews of provider client files and aides had been limited. In addition, QA's goal of reviewing each of the 380 providers every 2 years had not been met. (See page 10)

RCF billings not reviewed on regular basis

Residential care facilities (RCF) also provided personal care services to approximately 8,700 home and community-based services clients during fiscal year 2005. However, until December 2005, QA personnel had not reviewed RCFs to ensure billed personal care services had been provided. QA's review of 6 RCFs revealed $241,000 in overbilling at those facilities. (See page 13)

No review of Mental Health's employee disqualification registry

Review of DHSS's efforts to detect disqualified provider employees disclosed 16 disqualified individuals on Mental Health's employee disqualification registry that may have worked with clients from July 2000 through May 2006. Thirteen of these employees worked in the home and community-based services program, while three additional individuals worked as aides in the consumer directed care program. (See page 14)

Excluded providers not reviewed

DHSS personnel did not review RCFs to determine whether those providers had been included on the U.S. Department of Health and Human Services' OIG exclusion listing. According to state law, the department is required to investigate whether or not principals in the operation are excluded from Medicaid, because it cannot issue a license to an RCF if any principals involved in the operation are excluded from participation in Medicaid. (See page 16)

Adequate oversight of providers lacking	DHSS lacked oversight of provider billings and other deficiencies because it did not establish an adequate management reporting system capable of providing useful information on providers. QA is transitioning to an automated reporting system, but it will be approximately a year before it is fully implemented. (See page 17)
DMS efforts limited	DMS initiated recoupment of approximately $503,000 in program funds during fiscal year 2005. However, potential recoupments have been minimal because DMS audits of home and community-based providers have been limited. DMS did not dedicate adequate staff resources to review program providers for possible overbilling and/or fraud. Recoupments have also been minimal because of limited referrals from QA to DMS personnel. (See page 18)
Opportunities may exist to further standardize authorized services	In 2004, we reported DHSS had not established criteria to determine and control the number of personal care service hours Medicaid clients could be authorized on a statewide basis. DHSS implemented one of two recommendations related to that situation. Follow-up efforts disclosed DHSS has made some progress in achieving more uniform allocation of personal care services. However, the St. Louis region continued to exceed other regions in terms of authorized services and, although officials had conducted some analyses of why it occurred, these analyses were not adequate to determine why the differences existed. Officials implemented our recommendation to improve the timeliness of violation notifications to providers. (See pages 6 and 25)

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Abbreviations

CSR	Code of State Regulations
DHSS	Department of Health and Senior Services
DMS	Division of Medical Services
EDR	Employee Disqualification Registry

FCSR	Family Care Safety Registry
GAO	U.S. Government Accountability Office
OIG	Office of Inspector General
QA	Quality Assurance
RCF	Residential Care Facility
RSMo	Missouri Revised Statutes
SAO	State Auditor's Office

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Honorable Matt Blunt, Governor
and
Jane Drummond, Director
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and
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The state spent approximately $233 million during fiscal year 2005 for home and community-based services provided to Medicaid eligible elderly and disabled individuals. We focused our audit efforts on determining (1) whether improvements are needed in the state's ability to detect and recoup improper program payments to providers, and (2) the status of recommendations addressed in our 2004 report titled "Medicaid Personal Care Services Program" (Report No. 2004-02).

We found improvements are needed in the Department of Health and Senior Services' (DHSS) ability to detect and recoup overpayments to providers. The department's efforts to identify overbilling by providers has been limited because its role in identifying overpayments has not been clearly defined and because of limited reviews of provider client files, limited efforts to detect aides not providing services, and untimely reviews of providers. In addition, reviews of residential care facilities have not been conducted, reviews of employee disqualification listings have been limited, and reviews of federal exclusion listings have not occurred. We also found the department's efforts to monitor providers have been hampered by its limited management reporting system. The department is implementing computer software which, within the next year, should enhance its ability to monitor providers. Also, efforts to recoup improper overpayments by the Department of Social Services, Division of Medical Services (DMS) have been hampered by its limited audits of providers and by the lack of case referrals to it by DHSS.

We also found the department implemented two of three recommendations made in our prior report. The department did not implement one recommendation relating to standardizing the level of services provided to clients in the state. Although actions taken by the department have resulted in some progress in this area, additional efforts are needed to determine why the level of home and community-based services provided to clients in the St. Louis region continue to exceed the level of services provided in other regions of the state. We have made recommendations to improve the oversight of the program.

We conducted our audit in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such procedures as we considered necessary in the circumstances. This report was prepared under the direction of John Blattel and key contributors to this report included Robert Spence, Anissa Falconer, and Michael Reeves.

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Introduction

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (the division), authorized services resulting in approximately $233 million in personal care expenditures during fiscal year 2005 for home and community-based personal care services provided to Medicaid[1] eligible elderly and disabled individuals. Medicaid funds the majority of these expenditures.

Program Provides Options

The General Assembly established the Missouri Care Options program (program) in 1992 and the Department of Social Services, Division of Aging implemented it in October of that year. In January 2001, the governor issued an executive order that moved the Division of Aging, including the program, to DHSS effective August 2001. One objective of the program is to give adults facing long-term care decisions access to information necessary to make informed choices about their care. Another is to moderate avoidable growth in Medicaid payments to nursing facilities through increased funding for home and community-based services for older adults.

Home and community-based services are offered to adults, 18 years and older, who are Medicaid eligible, or potentially Medicaid eligible, and in need of assistance. The division uses a screening process to inform persons considering nursing facility care of their options for care and the care settings best for them. Options are also offered to screened nursing facility residents for home and community-based services. Through the program, persons are identified that need state funded long-term care, and

- have low-level maintenance health care needs, but are medically eligible for nursing facility care,
- are considering long-term care and need to know all available care options,
- could reasonably have needs met outside a nursing facility, and
- prefer to remain in a home or community-based care setting.

Home and community services include personal care, general and heavy household activities, nursing, respite, adult day health care, and counseling. The primary funding sources for home and community-based services include general revenue, Medicaid, Social Services Block Grants, and the Older Americans Act. Through these programs, approximately 66,000 elderly, and persons with disabilities, are served each year.

[1] Medicaid is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low income and resources.

The Division of Medical Services[2] (DMS) manages the operations of the Medicaid program. DHSS is responsible for providing direct administrative functions required to provide personal care services. DHSS and the Department of Social Services have entered into an agreement to define each agency's duties. DHSS has agreed to monitor operations of contracted in-home providers, and to report instances of noncompliance to DMS. In turn, DMS agrees to review reports of provider noncompliance submitted by the division and to pursue sanctions or other necessary actions. The agreement does not assign responsibility for conducting reviews of approximately 600 residential care facilities (RCFs).

The division's quality assurance (QA) unit conducts reviews of about 380 program providers to determine whether the providers are operating in compliance with state statutes, state regulations, and contractual requirements. The QA unit conducts on-site reviews of the providers looking for compliance in 40 areas, including conducting proper Family Care Safety Registry (FCSR) screenings, properly reviewing the DHSS Employee Disqualification Listing, verifying that policies are in place to ensure that employees are not servicing immediate family members,[3] and ensuring that timesheets are completed according to guidelines.

State law[4] established the FCSR to protect children, the elderly, and disabled individuals in Missouri, and to promote family and community safety by providing information concerning caregivers. All personal care workers are required to register with the FCSR. When employers conduct an FCSR screening of potential employees, they will be notified if the individual is included on any of the lists reviewed, which include:

- The Highway Patrol's criminal record check system.
- Probable cause findings of abuse and neglect of children.
- DHSS's employee disqualification list.
- Mental Health's Employee Disqualification Registry (EDR).
- Foster parent licensure denials, revocations, and involuntary suspensions.
- Child-care facility license denials, revocations and suspensions.
- Residential living facility and nursing home license denials, revocations, suspensions and probationary status.
- The Highway Patrol's uniform law enforcement system for sexual offender registrations.

[2] Medical services is located within the Department of Social Services.

[3] Immediate family is defined as a parent; sibling; and child by blood, adoption, or marriage; grandparents; or grandchild.

[4] Sections 210.900 to 210.936, RSMo.

State law[5] disqualifies persons who refuse to register with the FCSR, or who are listed on any of the background check lists in the FCSR, from providing in-home services to clients, unless a good cause waiver is granted. Providers are required to request a FCSR screening on all prospective employees, according to DHSS regulations.[6]

Consumer directed care services added

In fiscal year 2006, the division began administering consumer directed care services. This program had previously been known as the Personal Care Attendant Services program, and had been administered by the Department of Elementary and Secondary Education. At the time the program transferred, approximately 6,000 consumers had been authorized to receive services.

Consumer directed care services are provided by a personal care attendant to persons with disabilities who are at least 18 years old and can direct their own care by hiring, training, and supervising an attendant. The services allow persons with disabilities to accomplish tasks they would normally do for themselves if they didn't have a disability, such as routine tasks and activities of daily living that allow them to reside in their own homes rather than in nursing facilities. The General Assembly made statutory changes to the program when it moved to DHSS. For example, Section 208.909.4, RSMo states that no state or federal financial assistance shall be paid for services provided by a personal care attendant who is listed on any of the background check lists in the FCSR unless a good cause waiver is first obtained from the department.

Status of Prior Recommendations

In our 2004 report,[7] we found DHSS had not established criteria to determine and control the number of personal care service hours Medicaid clients could be authorized on a statewide basis. Auditors discovered substantial differences in hours authorized among regions with no identified or documented factors justifying the variances. The department implemented one of two recommendations relating to this situation, and officials believe steps have been taken to achieve assignment of more uniform personal care services in the state. Follow-up efforts disclosed some improvements have been achieved in this area; however, Medicaid clients in the St. Louis region continue to have more personal care hours authorized than other regions.

DHSS agreed with our recommendation to establish additional guidelines to address the lack of timely notification of compliance violations found

[5] Section 660.317 (7) RSMo.

[6] 19 CSR 30-82.060 (18).

[7] "Medicaid Personal Care Services Program," January 13, 2004 (Report No. 2004-02).

during QA reviews of providers. We reported the department took up to 4 months after completing QA reviews to notify personal care service providers they were in noncompliance with state regulations. This situation allowed providers to continue to operate in violation of state regulations and created a risk of injury or harm to the provider's clients. See Chapter 3 for additional information.

Scope and Methodology

We conducted work at DHSS and the Departments of Mental Health and Social Services. We interviewed knowledgeable officials and personnel at those departments and reviewed program documentation needed to accomplish objectives. We also reviewed the cooperative agreement between DHSS and DMS.

We also searched for background information on home and community-based care programs in the eight surrounding states. We also reviewed U.S. Government Accountability Office (GAO) reports to determine the extent of improper Medicaid payments in other states and efforts made to recoup overpayments to determine what Missouri could possibly achieve in recoupments.

To determine whether additional oversight is needed to detect overpayments and potential fraud, we interviewed QA officials in Jefferson City and QA specialists in St. Louis and Kansas City. We reviewed the QA manual, various reports, including those used to monitor providers, and examined results of reviews done by QA. We interviewed an official in DHSS's Office of Special Investigations regarding cases referred for criminal investigation. We also interviewed officials from the DMS Program Integrity Unit and reviewed documentation regarding recoupments initiated. To determine the amount of overpayments and recoupments, we reviewed information on referrals to DMS, and recoupment information from DMS personnel and determined percentages recouped. We also obtained information on recoupments by the Attorney General's Office.

To determine whether owners and/or key officials of providers had been included on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusion list, we interviewed officials at the OIG and reviewed the OIG exclusion list. We also, interviewed officials from DHSS, Mental Health, and DMS regarding procedures for checking the OIG exclusion list.

To determine if provider employees had been included on the Department of Mental Health's EDR, we compared the Mental Health EDR as of April 3, 2006, to employment data and contacted providers to obtain additional

information about possible EDR problems. We also reviewed DHSS FCSR and Good Cause Waiver information for possible disqualified employees.

To follow-up on prior recommendations and determine whether additional standardization of authorized personal care services is needed, we interviewed field staff in Buffalo, Jefferson City, Springfield, and St. Louis to determine how they assessed and rated clients. We analyzed division screening data to determine average units of services authorized in each region. We also conducted a statistical random sample of unit authorization worksheets to determine what could cause higher levels of authorized hours in one area of the state. We also reviewed the results of DHSS's analysis of statewide unit authorizations. We also reviewed the QA letter tracking reports to determine timeliness.

We performed data reliability tests on the division's client screening data and found the data to be sufficiently reliable for report purposes.

We requested comments on a draft of our report from the Directors of the Departments of Health and Senior Services, and Social Services. We conducted our work between August 2005 and June 2006.

Additional Efforts Needed to Identify and Collect Overpayments

Improvements are needed in the state's efforts to identify and recoup overpayments of Medicaid funds authorized by the division. Recoupment of program funds has been minimal because division officials have not maximized efforts to identify overbilling by providers. This situation occurred because the division's role in identifying overpayments has not been clearly defined, and because its reviews of providers have been limited, reviews of providers have not been timely, and RCFs have not been reviewed on a regular basis. In addition, DHSS has not established adequate procedures to ensure persons on the Mental Health EDR are not working with clients, and excluded providers have not been reviewed. The division also has not established a management reporting system that provides officials with an adequate overview of problem providers.

Recoupments by DMS have been minimal because of limited audits by DMS and by few referrals to DMS. As a result, improper billings, or possible fraud, may have gone undetected.

Recoupment of Overpayments Limited

During fiscal year 2005, DMS initiated recoupment of approximately $503,000 in program funds,[8] primarily as the result of QA provider reviews. Therefore, recoupment of Medicaid funds amounted to only .2 percent of $233 million in program expenditures for fiscal year 2005. (See page 18 for additional information on recoupment process.)

In 2001, GAO reported[9] on states' efforts to detect improper Medicaid fee-for-services payments. In that report, GAO discussed efforts by Illinois, Texas, and Kansas to identify the extent of improper payments. These states reported error rates of 4.7 percent, 7.2 percent, and 24 percent, respectively. For illustrative purposes, an error rate of 4.7 percent would equal approximately $11 million in potential improper payments based on fiscal year 2005 home and community-based services expenditures. If the error rate represented 1 percent, it would equal $2.3 million in improper program payments.

In February 2006, DMS's Director testified before the General Assembly's special committee to investigate Medicaid fraud that savings could be achieved by increasing program integrity unit staff. During that testimony the director stated that each program integrity reviewer can identify and avoid up to $500,000 per year in waste, fraud, and abuse.

[8] Does not include $21,000 in program funds recouped by the Attorney General's Office.

[9] "Medicaid: State Efforts to Control Improper Payments Vary" (GAO-01-662, June 2001).

Complaints sometimes identify overbilling

Hotline complaints provide information that sometimes leads to recoupments, according to a QA official. DHSS data for fiscal year 2005 disclosed DMS identified approximately $2,600 as the result of complaint calls.

Clients sometimes notify the department when services have not been provided. Other times, complaints come in from family members of the client or from disgruntled employees, according to the official. Hotline complaints will be investigated by field staff. If it appears to be a systemic problem involving the provider, field staff will complete a provider complaint form which will cause QA to become involved, according to the official. According to the official, QA personnel conduct a review based on the complaints and if additional problems are found, the review is expanded. Any instances of possible overbilling are turned over to DMS for recoupment. If, at any time, it appears that the situation is criminal in nature, it is referred to the DHSS Office of Special Investigations, according to QA officials.

Efforts to Detect Overbilling Limited and Not Timely

The division has relied on its QA process and hotline complaints to detect provider overbilling. However, QA's review process provides less assurance overbilling will be detected because QA's (1) responsibilities to detect overbilling have not been clearly defined, (2) reviews of provider client files and aides have been limited, and (3) goal of reviewing each of the 380 providers every two years has not been met.

DHSS's role not clearly defined

Effective August 2001, DHSS entered into a cooperative agreement with DMS that states division personnel are to review provider operations. However, the agreement did not clearly define QA's responsibilities to detect overbilling and/or fraud. The agreement states, in part, the following.

> DHSS will provide qualified staff to monitor the operations of contracted in-home providers. The monitoring will include a sample comparison of the plan of care to applicable documentation and remittance records to ascertain whether or not the provider delivered the services in accordance with the standards and care plan and as reimbursed by the Department of Social Services. DHSS will coordinate with DMS to provide technical assistance at the request of in-home services providers. DHSS will report instances of provider noncompliance to the Department of Social Services and jointly pursue sanctions or any other remedy including termination when necessary to remedy noncompliance.

According to a QA official, QA provides program oversight to find out if providers are in agreement with state statutes and provider agreements (contracts). They sometimes detect fraud while reviewing providers, however, abuse, neglect, fraudulent timesheets, and fraudulent billing practices are usually uncovered through hotline calls, according to the official. QA uses a monitoring tool which specifies the review should ensure providers are in conformance with statutes, regulations, and provider agreements, but it does not address overbilling.

If deficiencies are found involving billing by providers, QA personnel turn findings over to DMS for further investigation and possible recoupment, according to QA personnel. DMS is also responsible for identifying overbilling in the program, because they have oversight of all Medicaid programs. However, it is a partnership between DMS and QA, according to the official. (See page 18 for additional information on DMS' role.)

QA limits number of client files reviewed

QA reviews of providers include reviewing provider client files on a sample basis, according to a QA official. However, the review is usually limited to between 5 and 15 client case files, depending on the number of clients served by the provider, for a one-month sample time period.[10] According to DHSS provider data, the number of clients served by providers ranges from 1 to 2,851 for an average of 127. Using QA sampling criteria, QA would sample 5 cases (4 percent) of 127 cases.

QA policy stated for providers with 1 to 500 clients, 5 client files are to be tested which results in a 100 percent sample for 5 clients and a 1 percent sample for 500 clients. For 500 to 1,000 clients, 10 client files are to be sampled which results in a sample of 2 percent for 500 and 1 percent for 1,000 clients. For providers with over 1,000 clients, 15 client files (1.5 percent or less) are to be tested. If the provider has less than 5 clients, all are to be tested. The guidance also stated the sample may be expanded based on findings during QA reviews or based on the history of the provider. However, the policy did not provide any guidance on how much to expand the test of client files.

According to a QA official, if personnel find a problem when reviewing client files, the sample size would be expanded to determine whether the problem continued. The timeframe reviewed would also be expanded beyond a month, if compliance issues are found, and it would be up to the QA reviewer to determine how much to expand the timeframe. According to

[10] One month is to be selected from the previous 6 to 12 months.

three QA specialists, reviews have been expanded, but the extent has been left up to QA personnel.

QA file review limited

A QA official told us department procedures allow detection of potential provider overbilling. However, procedures are limited to reviewing provider visit reports in sampled provider client files to determine whether the reports have been filled out properly. For example, department policy requires QA personnel verify whether all required elements such as time in, time out, tasks done, aide's signature, and supervisor's signature have been included on the report. If any of these elements are missing, QA copies the information and submits it to DMS for possible recoupment, according to the official. QA also relies on DMS to determine whether the provider billed Medicaid for the visit.

QA personnel also review for provider compliance by determining whether aides have been included on the department's employee disqualification listing, and whether services have been provided by an aide doing advanced personal care tasks without proper training. If these situations are found it is also basis for recoupment, according to a QA official. During provider reviews the name and social security numbers for all staff are obtained. QA then selects a separate sample to cross-check provider aides against the disqualification listing. In addition, aides working for clients selected during the client review are reviewed to ensure provider background checks have been done, the FCSR has been checked, necessary training has occurred, and evaluations completed, according to the official. If found, non-compliance cases are also turned over to DMS personnel for possible recoupment of program funds.

Efforts to detect aides not providing services limited

When reviewing providers, QA personnel also conduct client interviews which could detect aides that have not provided authorized services for clients. However, personnel limited client interviews to two interviews for every provider reviewed, in accordance with QA policy. The policy includes questions for clients such as the name of the aide, the number of days during the week the aide works, the time the aide arrives and leaves, how long the aide stays, and what the aide does for the client.

According to a QA official, field staff are in constant contact with the clients and problems are usually brought up with the provider complaint form so they only need to interview two clients. In addition, interviews are normally conducted in clients' homes, and therefore, QA staff can assess home conditions and the client, according to the official. If the aide should have been at the home shortly before the interview, but the home is a "wreck", QA staff know to question the client more carefully, and to look more closely into that aide's work, according to the official.

The official also told us QA personnel rarely get complaints from client interviews because the clients are worried about losing an aide or the provider. The official plans to supplement the client interviews with telephone satisfaction surveys in the first quarter of fiscal year 2007.

QA provider review goal not met

During fiscal year 2005, QA personnel conducted quality reviews for 108 (28 percent) of 380 providers, according to documentation provided by a QA official. However, the department's goal requires providers be reviewed by QA personnel every 2 years to determine whether providers are following department and federal guidance. Since approximately 380 providers existed during fiscal year 2005, approximately 190 should have been reviewed for that year.

QA not staffed adequately

As of June 30, 2006, QA has 10 field staff,[11] plus 2 support staff in Jefferson City that help out as needed. These staff must conduct reviews of 296 in-home service providers, 58 adult day care providers, 4 counseling providers, and 22 independent living centers.[12] According to a QA official, if QA had more staff, providers could be reviewed more frequently. In addition, the QA staff could concentrate on problem providers, either helping to correct problems, or eliminating them as providers. Having more staff would eventually allow DHSS to have a better pool of providers, according to the official.

The official also stated more staff time is spent with problem providers, due to hotline calls and complaints. According to the official, the better providers would actually like QA staff to come more frequently so that problems could be corrected more timely.

RCF Billings Not Reviewed on Regular Basis

RCFs also provided personal care services to approximately 8,700 home and community-based services clients as of June 2005. However, until December 2005, QA personnel had not reviewed RCFs to ensure that billed personal care services had been provided.[13]

According to QA personnel, they have not reviewed RCFs because department officials have never assigned RCF reviews to QA. According to a DMS official, DMS personnel have reviewed RCFs on occasion, when

[11] Four of the ten staff had not been expected to conduct reviews until July 2006, according to a QA official.

[12] The 22 centers came under QA's jurisdiction in 2005, when the consumer directed care program became a part of the program. QA does not anticipate starting to review these facilities until July 2006.

[13] Chapter 198, RSMo and 19 CSR 30-86.042 explain that DHSS's Division of Regulation and Licensure, Section for Long-Term Care, issues RCF licenses and monitors RCFs.

referrals or complaints have been received. However, DMS has not conducted reviews on a regular basis. Our review of DMS recoupment data disclosed DMS reviews of RCFs resulted in recoupments. For example, during fiscal year 2005, DMS reviewed six RCFs and recouped approximately $403,000.[14]

Since DHSS has overall responsibility for authorizing personal care services at RCFs, sound business practices dictate the department ensure that services authorized are actually provided.

Limited review of RCFs revealed overbilling

In December 2005 and February 2006, QA personnel reviewed six RCFs, to determine what reviewing RCFs would entail, according to QA personnel. QA's review of the six RCFs revealed $241,000 in overbilling at these facilities. QA personnel referred the cases to DMS personnel for recoupment. For example, DMS personnel have initiated the recoupment process on two cases of approximately $140,000 (94 percent of the amount billed) and $88,000 (100 percent of the amount billed) as of March 31, 2006, for fiscal year 2005 activity reviewed.

QA began reviewing RCFs on a regular basis in June 2006 and plans on reviewing six each month. However, as discussed on page 13, QA has not met its goal of reviewing all providers every 2 years.

No review of Mental Health's EDR

Review of the department's efforts to detect disqualified provider employees disclosed 16 disqualified individuals[15] on Mental Health's EDR that may have worked with clients from July 2000 through May 2006. Thirteen of these employees worked in the home and community-based services program, while three additional individuals worked as aides in the consumer directed care program. Approximately $7,000 had been paid to the three disqualified consumer directed care aides from October to December 2005 for services.[16] This situation occurred because DHSS had not compared Mental Health's EDR to provider employment information. In addition, the division had not established procedures to notify providers of additions to Mental Health's EDR. We also found providers had not always conducted required screenings for new employees.

State law disqualifies persons on Mental Health's EDR from working with clients in the home and community-based program. Additionally, state law

[14] Of this amount, one RCF is appealing its case for approximately $156,000.

[15] One individual worked for two different providers while disqualified.

[16] The amount paid to the 13 disqualified individuals through the home and community-based care program was not readily available in DHSS data.

does not allow state or federal monies to be paid to persons on the Mental Health EDR for aide services provided in the consumer directed care program. Therefore, services performed by disqualified employees would not be eligible for reimbursement through the home and community-based services program, unless a waiver is granted based on prior work history and other factors.

Division officials had not been aware of these disqualified persons working with clients until we brought it to their attention. The officials could not provide rationale for why comparisons of the Mental Health EDR to provider employment information had not been made.

Providers not notified of additions to Mental Health's EDR

Although DHSS personnel have established procedures to notify providers of additions to the DHSS employee disqualification list, they had not established procedures to notify providers of additions to the Mental Health's EDR. For example, a review of DHSS information showed providers conducted proper FCSR screenings on four employees. When providers conducted the FCSR screening, the employees had not been added to Mental Health's EDR. After the providers hired the employees, Mental Health added the employees to its EDR. However, because DHSS does not notify providers of additions to the Mental Health's EDR, the providers had no way of knowing the employees had been disqualified. As a result, these employees continued to be employed by providers between 4 and 18 months after being added to the Mental Health's EDR.

A program official was aware of Mental Health's EDR, but could not provide an explanation as to why program personnel had not notified providers of EDR information.

Providers not always conducting required screenings

Provider administrators have not always conducted FCSR screenings for new employees as required by DHSS regulations.[17] For example, DHSS information disclosed providers did not perform FCSR screenings for 5 of the 13 disqualified individuals.[18] DHSS policies require FCSR screenings to be completed for all employees working with DHSS clients.

When we contacted provider personnel, they confirmed those employees had been working with DHSS clients during the timeframe in question. Providers had employed these disqualified persons from 2 months to more than 4 years.

[17] The FCSR includes a review of Mental Health's EDR.

[18] Employees working in the home and community-based services program discussed on page 14.

QA not always aware of situation

QA's normal means of becoming aware of the situation discussed above is through its reviews of providers. However, QA's review of providers has been limited to about once every three years and its review of employee files has been limited to five during each provider review. See pages 11 and 13, for additional discussion.

Excluded RCFs Not Reviewed

DHSS personnel have not reviewed RCFs to determine whether those entities[19] have been included on the U.S. Department of Health and Human Services' OIG exclusion listing. According to state law,[20] during the application process DHSS is required to investigate whether or not principals in the operation are excluded from Medicaid, and cannot issue a license to an RCF if any principals involved in the operation are excluded from participation in Medicaid.

The OIG included approximately 37,000 individuals and businesses on its list of excluded providers as of May 2006. According to an OIG general counsel official, if an excluded person worked for a provider, i.e., a nursing home, a RCF, or a pharmacy, then related billings would be considered overbillings and the Medicaid payments would be improper payments. Medicaid moneys should not be paid to businesses that employ or are owned by excluded individuals, according to the OIG official.

DHSS not determining whether RCFs are on excluded listing

According to DHSS long-term care personnel,[21] they have responsibility to not license excluded RCFs. However, long-term care division personnel told us they do not normally determine whether RCF operators or employees have been listed on the excluded list. Instead, they have relied on a notarized statement affirming that neither the operator nor any principals in the operation of the facility are on the exclusion listing. Personnel also stated in cases where the OIG investigated an operator, or employee, of a long-term care facility, the OIG notified long-term care personnel about the investigation and informed them if the operator or an employee had been added to the exclusion list.

[19] Includes RCF officials also.
[20] Section 198.022.1 (5), RSMo.
[21] The Division of Regulation and Licensure, Section for Long-Term Care.

No assurance by other agencies that RCFs owners and/or principals are not on excluded listing

DMS is the Medicaid agency for the state. As such, RCF claims for personal care services are submitted to DMS and payment is made through its system. However, as of March 22, 2006, provider enrollment personnel had not compared new Medicaid provider applicants to the OIG exclusion list on a regular basis, according to DMS personnel.[22] In regard to RCFs, provider enrollment personnel assumed DHSS reviewed this information, if it needed to be reviewed, because the department's long-term care division is the primary licenser of RCFs. In discussing this matter in early June 2006, provider enrollment personnel advised us that personnel began comparing new providers to the listing. However, they are not determining whether owners and/or principals are on the listing because they do not have the necessary information.

Adequate Visibility of Providers Lacking

DHSS lacks visibility of provider overbilling and other deficiencies. This situation has occurred because the department has not established an adequate management reporting system to provide QA and department officials with useful summary information on providers. QA is transitioning to an automated reporting system, but it will be approximately a year before it is fully implemented.

Sound business practices dictate the department have effective oversight of providers. One technique used by organizations to assist oversight is the establishment of a management reporting system. For example, an effective reporting system could provide officials with summary and/or trend information on providers repeatedly cited for deficiencies and/or overbilling Medicaid.

Current QA reporting limited

As of June 2006, QA had no overall report, or annual summary report, showing providers deficient in given areas or providers and/or aides that had overbilled DHSS for services, according to a QA official. Instead, anytime a question of this type has been raised, QA personnel prepared a report manually, according to the official. For example, if department officials wanted specific information on deficiencies found at providers for fiscal year 2005, individual reports would have to be pulled showing this information and summarized manually.

QA staff prepare monthly review activity reports addressing activities such as the number of surveys completed and number of deficiencies noted at providers. However, until December 2005, QA had no overall report showing monthly activity. In December 2005, a QA official began preparing

[22] After providers are approved to participate in the Medicaid program, DMS's Program Integrity Unit staff checks the OIG monthly exclusion list for continued eligibility.

a monthly report summarizing QA's monthly activity using reports from staff. According to the official, no other reports have been prepared on a regular basis. Also, see Chapter 3 for information regarding QA efforts to track timeliness of compliance violation notices to providers.

QA implementing automated reporting system

In March 2006, QA implemented computer software that will allow division personnel to generate reports showing statewide statistics for providers reviewed, according to a QA official. The software will allow personnel to maintain a history of reviews by provider. The official anticipates that it will be approximately a year before QA will have sufficient data to analyze in order to produce reports for use by the unit. Officials stated that the new software will allow them to review deficiencies statewide or by region. They plan to use the software when selecting topics for training staff and providers.

DMS Efforts Limited

During fiscal year 2005, DMS recouped approximately $503,000 on behalf of the program. However, potential recoupments have been minimal because DMS audits of home and community-based providers have been limited. This situation has occurred because DMS has not had adequate staff dedicated to reviewing program providers for possible overbilling and/or fraud. Recoupments have also been limited because of limited referrals from QA to Program Integrity Unit (unit) personnel.

The unit is responsible for conducting post-payment audits/reviews and researching recipient complaints for all Medicaid providers, including home and community-based personal care services. In regard to identifying overpayments, a DMS official told us DHSS and DMS are jointly responsible for detecting overpayments and fraud. (See page 10 for discussion on cooperative agreement.) The two units work together and meet quarterly to discuss pending cases, cases that are closing, and actions taken, according to the official.

Limited audits and referrals hamper effort

During fiscal year 2005, three DMS staff conducted in-home provider audits. However, as of July 2005, unit staff assigned this responsibility had decreased to one person, according to a unit official. After the reduction in unit staff, only cases referred by QA personnel were reviewed. According to unit personnel, the unit has no plans to audit all providers, which totaled approximately 380. Instead the unit focuses its efforts on problem providers referred by QA staff. Beginning in February 2006, three additional staff began working on QA referrals on a part-time basis.

According to unit personnel, the unit did not receive many QA case referrals until June 2005. At that time, and in early fiscal year 2006, referrals increased. Because unit staff had not received many referrals from QA

personnel in fiscal year 2005, staff used unit generated reports to select providers for review. These reports would flag providers based on various problems. Unit staff would then conduct on-site audits for providers located in St. Louis. For selected providers not located in St. Louis, personnel would conduct "desk" audits, according to unit personnel. During fiscal year 2006, unit personnel no longer conducted self-initiated audits.

QA personnel turn over review information with potential overpayments to DMS personnel. Unit personnel then limit their review of the case by reviewing only those allegations received, comparing copied timesheets, and reviewing a DMS report showing payment history for the client. Unit personnel review the payment history to determine whether or not an overpayment occurred. If overpayment occurred, unit personnel notify the provider and initiate the recoupment process, according to unit personnel.

Suspected fraud referred to Attorney General's Office

If unit personnel suspect fraud, the case is turned over to the Attorney General's Office for further investigation, according to DMS officials. In fiscal year 2005, DMS referred two cases to the Attorney General's Office which were still in process as of June 30, 2006. DMS personnel may also pursue collection of overpayments on cases referred to the Attorney General's Office.

Conclusions

Additional efforts are needed to identify and collect overpayments. Clarifying its role in identifying overbilling and increasing the number of client files reviewed by QA personnel would enhance DHSS's opportunities to find potential overbilling by providers. Additional guidance is also needed to assist personnel in determining how much to increase testing of client files when overbilling is suspected. Client file reviews have also been limited to determining whether all required elements have been filled out on appropriate forms. Increasing the number of interviews with clients could also increase opportunities to identify overbilling and/or fraud. The department should also determine the number of staff needed to meet its 2-year review goal and increase staff assigned to this task to meet that goal.

Based on results achieved through limited review of RCFs, QA should continue to review RCFs. DHSS should institute review procedures and increase staff to accomplish these reviews. In addition, DHSS should review Mental Health's EDR and notify providers of additions to that registry. Doing so would enhance opportunities to identify overbilling by providers that have disqualified personnel providing services. The department should also ensure providers conduct required screenings of providers.

DHSS personnel have not reviewed RCFs to determine whether those facilities have been included on the OIG's exclusion listing. DHSS long-

term care personnel should perform this function to identify potential overbilling and fully comply with state law.

In March 2006, QA implemented computer software that should provide officials with information on providers that have been reviewed. However, it will be about a year before QA will have sufficient data to analyze. Once fully functional, the department should undertake an in-depth evaluation of its management reporting requirements in order to ensure the new system meets its needs.

Recoupment of program funds has also been limited because DMS has limited its audits of program providers and because of limited referrals to it by QA staff. The Department of Social Services has not dedicated an adequate number of staff that would allow DMS to initiate audits of program providers and/or expand on referrals by DHSS. Social Services should determine DMS staffing needs and meet those needs. By increasing staff assigned to this task, recoupments of overbilling and/or fraud should increase significantly.

Recommendations

We recommend the Director of the Department of Health and Senior Services increase efforts to minimize, identify and recoup overbilling by:

2.1 Clarifying the department's role in identifying provider overpayments. This clarification should include clarifying whether the department or DMS will take the lead in identifying overpayments.

2.2 Increasing the number of sampled client files. Establishing uniform guidance for reviewers to follow when overbilling is suspected, and increasing the number of client interviews for each provider reviewed.

2.3 Increasing staff assigned to QA to increase coverage and meet the department's 2-year goal of reviewing providers.

2.4 Increasing staff assigned to QA and establishing procedures to review RCFs on a regular basis.

2.5 Determining the amount of potential overbilling by providers identified through SAO's review of Mental Health's EDR and refer results to DMS for recoupment.

2.6 Comparing employment information to Mental Health's EDR to identify disqualified employees in the home and community-based program and the consumer directed care program.

2.7 Requiring staff to notify providers of additions to Mental Health's EDR.

2.8 Ensuring provider staff are conducting FCSR screenings.

2.9 Ensuring RCF owners and principals are not on the OIG exclusion list before issuing licenses.

2.10 Assessing the management reporting system once fully operational to ensure it meets the department's needs.

We also recommend the Director of the Department of Social Services enhance efforts to recoup home and community-based services funds by:

2.11 Increasing program integrity unit staff to allow DMS personnel to initiate provider audits as well as expand audit efforts on referrals by DHSS.

Agency Comments

Department of Health and Senior Services Comments

2.1 Although the DSS and the Office of the Attorney General have primary statutory authority for Medicaid fraud activities, DHSS contributes to these efforts by identifying billing errors and documentation problems discovered during quality reviews of home care entities. When overpayments are suspected, information is referred to DSS, Division of Medical Services (DMS) as part of DHSS' role of ensuring quality oversight of home care entities. The two departments hold quarterly meetings to promote this shared responsibility. DHSS will clarify directives for Quality Assurance (QA) specialists regarding the responsibility for identifying and the process for referring billing errors to DSS/DMS. Additionally, DHSS will review the Cooperative Agreement between DSS and DHSS to clarify language related to overpayments and Medicaid fraud.

2.2 DHSS believes that the current sample criterion has been effective in identifying deficient practices, sanctioning providers and terminating contracts. Although DHSS will continue to review staff allocations, the impact of increased sample sizes must be weighed against goals for conducting annual on-site visits and responding to complaints. DHSS will provide QA specialists with written directives regarding the additional activities that must be completed when overbilling is suspected and continue to review staff allocation.

2.3 Four FTE have been allocated by the state legislature to the department for conducting quality oversight activities. DHSS has temporarily assigned several staff positions to the Bureau of Quality Assurance (BQA) in an effort to maximize home care oversight. DHSS will continue to evaluate staffing resources, and provide oversight within current staffing levels—using staff assigned to BQA (from the Bureau of Home and Community Services). Additionally, DHSS will continue to explore alternative processes to strengthen quality oversight.

2.4 DHSS has implemented a review tool for assessing the quality of care delivered in Residential Care Facilities. Although not required by statute or regulation, DHSS anticipates conducting quality reviews of fifty RCFs in the current fiscal year – however, this plan is subject to adjustment based on workload variables.

2.5 DHSS has identified and made referrals to DMS based on information provided by SAO.

2.6 The statutory authority to access the Department of Mental Health's EDR is part of the Family Care Safety Registry (FCSR) screening requirements. Although statutes require providers to ensure potential employees are not on the EDR, the method and frequency that providers can and must access updated EDR information is unclear. DHSS will review statutes and/or regulations and consult with DMH to determine if amended language could strengthen protection of home care recipients. DHSS will also continue to identify and cite deficient practices, initiate provider sanctions and proceed with terminations when it is determined that clients are at risk due to non-compliance with FCSR and EDL screening mandates.

2.7 DHSS does not have statewide access to the EDR – nor does DHSS have continuous access to information regarding provider employees. DHSS will review statutes and/or regulations and coordinate with DMH to determine if amended language could strengthen protection of home care recipients.

2.8 The BQA identifies non-compliance with FCSR requirements as part of the Quality Assurance focus review. BQA identifies, cites and requires corrective action plans when providers are non-compliant. Providers violating the FCSR and/or Employee Disqualification List (EDL) requirements that place clients at risk remain on sanctions until BQA verifies operations to be in compliance. Based on the seriousness of

the violations, providers found to be out of compliance with FCSR requirements have been denied participation agreements.

2.9 Division of Medical Services (DMS) issues provider participation agreements to RCFs based on compliance with licensing statutes of DHSS. As indicated in the audit report, DHSS requires RCF applicants to provide a sworn statement regarding federal exclusions as part of the licensure process. Additionally, the application for licensure requires the applicant to respond to the following direct statement regarding exclusion:

> *"12b. Is the operator or any principal in the operation of the facility under exclusion from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory? Yes No"*

DHSS has authority during the application process to request additional information, expand the background investigation, and take any action deemed appropriate when there is reason to believe an owner/operator/principal has withheld information – including that related to the OIG exclusion list. Although DHSS is not aware of any instance of an owner/operator being granted a license to operate a long-term care facility that was on the OIG exclusion list, the Section for Long Term Care began requiring social security numbers of RCF owners/operators/principals as part of the application process effective August 2006. The Social Security Number, once obtained, will be used to compare the owner/operator /principal against the OIG exclusion list.

2.10 DHSS will continue to assess and refine the management reporting systems. The reporting system being implemented (ASPEN) provides the state the opportunity to trend and track cited deficiencies statewide and is available to DMS – enhancing communication regarding provider performance.

Department of Social Services Comments

2.11 DSS is cognizant of the cost of adding staff and has maximized its existing resources to prioritize its reviews by recovery potential. DSS has 25 program integrity staff to review approximately 22,000 enrolled providers and approximately 850,000 enrolled recipients. DMS has fourteen staff conducting provider reviews (ratio of 1:1571 providers), three staff conducting recipient reviews (ratio of 1:283,333 recipients), with the other eight conducting critical supporting functions. Among the available resources, DSS has a Fraud Abuse

Detection System that uses computer-based algorithms to analyze literally millions of claims for identification of potential overpayments or misconduct by providers or recipients. In this way, DMS can target its review activities to those cases that have been systematically identified with a potential problem rather than reviewing all providers/recipients to weed out those with no problems. DSS has increased its avoidance of costs and identification of cost recoveries by almost five-fold from $5.5 million in SFY 2004 to $23.4 million in SFY 2006 by using these targeting techniques. DSS does not believe adding additional staff for the sole purpose of reviewing only home and community providers is a wise investment of staff resources. If staff were added to program integrity, assignments would be based on global program integrity needs rather than limiting activities to a single type of provider.

Opportunities May Exist to Further Standardize Authorized Services

DHSS has made some progress in achieving more uniform allocation of personal care services. The improvement in allocation of services occurred because the department required personnel to use a unit authorization worksheet. However, the St. Louis region continued to exceed other regions in terms of authorized services and, although officials have conducted some analyses of why it occurred, additional analyses are needed to determine more fully why the differences exist. Department officials implemented our recommendation to improve the timeliness of violation notifications to providers.

Changes Contribute to Improved Uniformity

Department officials believe changes made to the program have achieved more uniform services statewide. However, hours authorized for personal services for the St. Louis region still exceed other regions.

In October 2003, DHSS began requiring the use of a uniform unit authorization worksheet by all field staff to assist personnel in determining the appropriate number of units of each service to be authorized for all clients who receive in-home services. Guidance issued required personnel to complete the worksheet when initially assessing the client and any time changes are made in the number of units or type of services authorized. According to the guidance, the worksheet is intended to promote more consistent authorization of services.

Although program analysis and management actions have resulted in more consistent authorization of hours statewide, hours authorized in the St. Louis region continue to be higher than those authorized in other regions. Good business practices dictate that management conduct more comprehensive analyses to determine whether field staff in the St. Louis area have been justified in authorizing more personal care services hours than authorized by field staff in other regions.

Service hours lowered, but still higher than other regions

Our analysis of department data[23] for fiscal year 2005 showed the department had made some progress in reducing the difference between the number of authorized service hours for the St. Louis region and the remainder of the state. For example, our analysis of personal care hours[24] disclosed personal care service hours authorized for that region averaged about 56 hours, or 87 percent higher than the lowest region's average

[23] Auditor analysis of initial referrals for fiscal year 2005.

[24] Includes personal care, advanced personal care, nurse visits, homemaker chore services, adult day health care, and respite services.

hours.[25] Although this is significantly higher than the lowest region, it is an improvement over what we found during our prior audit. Our analysis of service hours for the Kansas City Metro region[26] averaged about 37 hours, or 23 percent higher than the lowest region.

During our prior audit, we compared average care scores to hours of services for five regions and found all five regions to be consistent in level of care scores for clients. However, we found inconsistencies in personal care services hours authorized for three of the five regions. For example, we found hours authorized for the St. Louis City and Kansas City Metro regions exceeded other regional areas. We found field staff authorized 63 hours for clients in the St. Louis City region compared to 29 hours for the Columbia region. The difference of 34 hours represented a variance of 117 percent. St. Joseph field staff authorized 24 hours of services for clients while Kansas City Metro region field staff authorized 59 hours for clients. The difference of 35 hours represented a 146 percent variance in hours.

More authorized hours increases cost of program

We also found increasing the personal care hours increased the cost of the program. For example, we previously found the average monthly cost for St. Louis City[27] was about twice the average monthly cost for St. Joseph and Columbia during fiscal year 2002 and about 57 percent higher than Kansas City during fiscal year 2003. Our analysis of Medicaid data for fiscal year 2003 showed the St. Louis City region had the highest cost average of $529 a month and the Kansas City Metro region averaged $337 a month. These amounts represented significantly higher average costs when compared to the average monthly cost of $289 and $265 for Columbia and St. Joseph regions, respectively.

Current analysis of fiscal year 2005 data showed the average monthly cost of authorized services for new clients in the St. Louis region to be about 60 percent higher than for new clients in the Springfield and Central Missouri regions, and 30 to 40 percent higher than the remainder of the state. Services authorized for new clients in the St. Louis region averaged $743 a month, while the Southeast Missouri region, Northeast Missouri region, and the Kansas City region averaged $571, $537, and $533 respectively. The lowest monthly costs averaged $461 and $455 in the Springfield and Central Missouri areas respectively. Using the average cost for new clients for the

[25] Region 6, which includes the central Missouri area, had the lowest average hours—30 hours.

[26] Also includes the northwest part of the state.

[27] At the time of the prior audit, St. Louis City and St. Louis County regions existed. These two regions were combined in February 2004.

St. Louis region and comparing that to the average cost of new clients in the other regions, we found the St. Louis region incurred $20 million in additional authorized services for fiscal year 2005.[28]

Further analysis of St. Louis region services needed

According to officials, program personnel have analyzed some reasons for increased services for the St. Louis region. For example, they found the St. Louis area has a higher percentage of clients under the age of 63 than the rest of the state. Clients under the age of 63 are not eligible for home delivered meals, which may result in clients receiving meals prepared in their homes by an aide, which is a higher cost service. Additionally, according to program officials, clients in the St. Louis area appeal negative decisions more often than clients in other regions.

Our test work showed that even among those clients eligible to receive home delivered meals, staff authorized more meal assistance[29] for clients in the St. Louis region than in the Central Missouri region. For example, the sample populations for both regions included 14 clients who could not prepare their own meals, but had someone to regularly prepare meals for them. In the central region, 5 (36 percent) of these clients received meal assistance, compared to 11 (79 percent) in the St. Louis region. In the central region, the average monthly cost of services for these clients represented $26, compared to $78 in the St. Louis region.

For illustrative purposes, we compared the percentage and costs of St. Louis region clients that received meal assistance during fiscal year 2005 with those in the central region. We randomly selected 47 of 867 new clients[30] in the St. Louis region and based on sample results, we estimate 738 (85 percent) of those clients received meal assistance. Using the same methodology, we estimate 50 percent of the clients in the central region had been receiving meal assistance. For comparison purposes, we assumed these percentages would be reflective of the total universe of clients for both regions. Therefore, based on the average cost of prepared meals for St. Louis region clients, the St. Louis region incurred approximately $1.5 million[31] more in costs than the central region. An official stated DHSS had not been aware personnel in the St. Louis region had been authorizing more

[28] For illustrative purposes, using the $743 as representative for all clients in the St. Louis region would equal total authorizations of $63 million for fiscal year 2005. This compares to $43 million, which represents the average cost for authorized services for the other regions.

[29] Meal assistance includes both home delivered meals and meals prepared in the home by an aide.

[30] New clients receiving services through the aged and disabled Medicaid waiver.

[31] See Appendix I for calculations.

meals than personnel in others regions and did not know why this had been occurring.

QA Improved Timeliness of Notices to Providers

In response to our prior audit recommendation to enhance the timeliness of compliance violation notices to providers, QA personnel revised informal guidelines in January and June 2004 to improve the timeliness of notices of violations to providers. According to QA documentation, QA revised guidance to expedite the review process, so notifications would be mailed out within 30 days of the review. Beginning in March 2006, QA again revised guidance, requiring letters to be mailed within 10 calendar days after the review.

QA database tracks providers

QA personnel created a database in July 2004 that tracks providers reviewed, when personnel send notification letters to providers notifying providers of review results (deficiencies or no deficiencies), and whether the provider had been sanctioned, according to a QA official. Monthly activity reports prepared by personnel are used to input the information in this database, according to the official.

Department data showed improved timeliness

Our analysis of department data showed the department issued notification letters three times faster during fiscal year 2005 than we found during our prior audit[32] and five times faster for fiscal year 2006.[33] For example, our analysis showed that for fiscal year 2005 the department experienced an average delay of 14 days with about 8 percent taking more than 30 days. For fiscal year 2006, the department experienced an average delay of 9 days with none taking more than 30 days.

Conclusions

DHSS has made some progress achieving more uniform allocation of personal care services. Although personnel have conducted some analyses of services provided to St. Louis region clients, more comprehensive analyses are needed to determine whether field staff in the St. Louis area have been justified in authorizing more personal care services hours than authorized by field staff in other regions. These analyses could assist officials in making further adjustments in the screening process or perhaps increase training efforts to ensure screening efforts are more uniform in the state.

Department officials have made changes to improve the timeliness of notices to providers. Guidelines issued have proven to be effective in reducing delays found in our previous review.

[32] During the prior audit, the department averaged a delay of 49 days.
[33] Through January 2006.

Recommendation

We recommend the Director of the Department of Health and Senior Services:

3.1 Conduct additional analyses of personal care services authorized for St. Louis region clients to determine if the proper level of services is being provided for those clients.

Agency Comments

3.1 Care plans, although individualized in accordance with unmet needs of the client, are developed in consultation with the client (or family/caregiver) and the provider. Although there is a presumption that care plans should generally reflect standard authorizations for comparable needs, the desires of the client and willingness to accept assistance is an integral component of the care planning process. DHSS has taken action to maximize the ability to ensure care planning policies are standardized – including worksheets for standard unit determination, initiated reports for evaluating service authorizations, and adding a quality review component to the authorization process. Managers analyze monthly authorization reports, identifying areas where additional efforts may be necessary to ensure training and care plan development oversight is adequate. DHSS also maintains ongoing evaluation of forms and policies to maximize statewide consistency in care planning. Additionally, as a safeguard against inadequate authorizations, recipients of Personal Care are entitled to administrative hearings if authorization levels are believed to be inadequate. The state, however, seeks to authorize care based on the needs of the client – in conjunction with the independent supports available and the degree of willingness to accept care into the home. If at any time clients are dissatisfied with services, workers assist the client in accessing due process through the administrative hearings process.

Sample Methodology And Results

This appendix describes how we identified study populations and our sampling methodologies for two probability samples.

St. Louis region

To determine the percentage of clients receiving meal assistance in the St. Louis region, we conducted testing on a probability sample of 47 clients from a study population of 867 new waiver clients who received an initial assessment in fiscal year 2005. We based sample size on a 90 percent confidence level with 7 percent precision and an expected error rate of 10 percent.

Based on sample results, we estimate 85 percent of the study population, or 738 clients in the St. Louis region with initial assessments in fiscal year 2005, received assistance with meals. Table I.1 displays sample results.

Table I.1: St. Louis Region Clients Receiving Meal Assistance

Category	Result
Sample size	47
Clients receiving meal assistance	40
Point estimate receiving meals	85%
Point estimate quantity	738
Upper limit receiving meals	93%
Upper limit quantity	803
Lower limit receiving meals	74%
Lower limit quantity	643

Central region

To determine the percentage of clients receiving meal assistance in the Central region, we conducted testing on a probability sample of 46 clients from a study population of 512 waiver clients who received an initial assessment in fiscal year 2005. We based sample size on a 90 percent confidence level with 7 percent precision and an expected error rate of 10 percent.

Based on sample results, we estimate 50 percent of the study population, or 256 clients in the Central region with initial assessments in fiscal year 2005, received assistance with meals. Table I.2 displays sample results.

Table I.2: Central Region Clients Receiving Meal Assistance

Category	Result
Sample size	46
Clients receiving meal assistance	23
Point estimate receiving meals	50%
Point estimate quantity	256
Upper limit receiving meals	62%
Upper limit quantity	319
Lower limit receiving meals	38%
Lower limit quantity	193

Cost Difference Calculation

We calculated the difference between the St. Louis and Central Missouri regions for authorized meal assistance services as follows.

Total number of St. Louis waiver clients as of June 2005	3,466
Multiplied by current rate of meal assistance in St. Louis	85%
Equals approximate number receiving meal assistance	2,946
Multiplied by average cost for meal assistance in St. Louis	$108
Equals total monthly costs for St. Louis meal assistance	$318,168
Total number of St. Louis waiver clients as of June 2005	3,466
Multiplied by current rate of meal assistance in central region	50%
Equals approximate number to receive meal assistance	1,733
Multiplied by average cost for meal assistance in St. Louis	$108
Equals total monthly costs for St. Louis meal assistance	$187,164
Estimated amount currently spent monthly on St. Louis meals	$318,168
Less estimated amount to be spent based on central region rate	187,164
Equals monthly difference	131,004
Multiplied by 12 months	12
Equals estimated annual difference	$1,572,048