

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE AGENCIES CLAIMED
UNALLOWABLE AND UNSUPPORTED
MEDICAID REIMBURSEMENTS
FOR SERVICES UNDER THE
HOME AND COMMUNITY-BASED
SERVICES WAIVER PROGRAM**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Deputy Inspector General
for Audit Services

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A-07-16-03212

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

State Medicaid agencies claimed unallowable room-and-board costs and certain other unallowable and unsupported costs, and as a result claimed at least \$176.5 million in unallowable and unsupported Federal Medicaid reimbursement for services under their home and community-based services waiver programs.

WHY WE DID THIS REVIEW

During eight recent Office of Inspector General audits of Medicaid home and community-based services (HCBS) waiver programs in four States, we determined that the State Medicaid agencies from these States (State agencies) claimed unallowable Medicaid reimbursement and, in the case of one State, Medicaid reimbursement resulting from unsupported payment rates for services under their HCBS waiver programs. This report summarizes the findings of those eight audits to help the Centers for Medicare & Medicaid Services (CMS) and all State Medicaid agencies achieve greater efficiencies in the operation of the Medicaid program.

Our objective was to summarize the results of our previous audits that identified instances in which State agencies did not comply with Federal requirements in administering their HCBS waiver programs.

BACKGROUND

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, 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.

Section 1915(c) of the Social Security Act authorizes Medicaid HCBS waiver programs. A State's HCBS waiver, which must be approved by CMS, allows a State to claim Federal reimbursement for services not usually covered by Medicaid. Within broad Federal guidelines, States may develop HCBS waiver programs to meet the needs of people who prefer to get long-term-care services and support in their homes or communities rather than in institutional settings. Nearly all States and the District of Columbia offer services through HCBS waiver programs. States may operate as many CMS-approved HCBS waiver programs as they want. Currently, more than 300 HCBS waiver programs are in effect nationwide.

WHAT WE FOUND

In our eight previous audits, we identified instances in which State agencies did not always comply with Federal requirements in administering their HCBS waiver programs. Specifically, we found that the four State agencies (Maryland, New York, Missouri, and South Carolina) did not always exclude unallowable room-and-board costs when determining payment rates under

the HCBS waiver program, resulting in at least \$90,857,898 (Federal share) in unallowable Medicaid reimbursement.

In addition, our previous reports conveyed the following other findings which, combined, resulted in a total of at least \$85,622,295 (Federal share) in unallowable and unsupported Medicaid reimbursement:

- Maryland did not always ensure that personal care services under the HCBS waiver program were provided by qualified personnel, supported by an approved plan of care, authorized, and properly documented, resulting in \$10,864,195 (Federal share) in unallowable Medicaid reimbursement;
- Maryland did not always provide add-on services (which are residential habilitation services provided in addition to those services covered under the per diem rate) only to beneficiaries who met the HCBS waiver’s level-of-need requirement for those services, resulting in \$34,155,857 (Federal share) in unallowable Medicaid reimbursement;
- Missouri did not always exclude unapproved costs when determining payment rates under the HCBS waiver program, resulting in \$1,455,378 (Federal share) in unallowable Medicaid reimbursement; and
- Missouri did not always ensure that all payment rates under the HCBS waiver program were properly supported and documented, resulting in \$39,146,865 (Federal share) for which we were unable to determine the allowability of Medicaid reimbursement.

The State agencies did not have adequate controls to ensure that their HCBS waiver programs complied with applicable Federal requirements regarding the need to exclude unallowable room-and-board costs when determining payment rates. In addition, Maryland and Missouri did not have adequate controls to ensure that certain other costs complied with the requirements associated with their HCBS waiver programs.

As a result of the inadequate controls regarding unallowable room-and-board costs and certain other unallowable and unsupported costs, the State agencies claimed at least \$176,480,193 (Federal share) in unallowable and unsupported Federal Medicaid reimbursement for services under their HCBS waiver programs.

WHAT WE RECOMMEND

We recommend that CMS:

- share the findings of our HCBS waiver program audits with all State agencies to reinforce Medicaid requirements that prohibit the inclusion of unallowable room-and-board costs when determining payment rates,
- share (at CMS’s discretion) the other findings of our HCBS waiver program audits with all State agencies, and

- encourage all State agencies to review their procedures for calculating and claiming costs under their HCBS waiver programs.

CMS COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described actions that it had taken or planned to take.

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INTRODUCTION

WHY WE DID THIS REVIEW

During eight recent Office of Inspector General (OIG) audits of Medicaid home and community-based services (HCBS) waiver programs in four States (Appendix A), we determined that the State Medicaid agencies from these States (State agencies) claimed unallowable Medicaid reimbursement and, in one State, Medicaid reimbursement resulting from unsupported payment rates for services under their HCBS waiver programs. This report summarizes the findings of those eight audits to help the Centers for Medicare & Medicaid Services (CMS) and all State Medicaid agencies achieve greater efficiencies in the operation of the Medicaid program.

OBJECTIVE

Our objective was to summarize the results of our previous audits that identified instances in which State agencies did not comply with Federal requirements in administering their HCBS waiver programs.

BACKGROUND

Medicaid Program

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, 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.

Home and Community-Based Waivers

Section 1915(c) of the Social Security Act (the Act) authorizes Medicaid HCBS waiver programs. A State's HCBS waiver, which must be approved by CMS, allows a State to claim Federal reimbursement for services not usually covered by Medicaid. Within broad Federal guidelines, States may develop HCBS waiver programs to meet the needs of people who prefer to get long-term-care services and support in their homes or communities rather than in institutional settings. Nearly all States and the District of Columbia offer services through HCBS waiver programs. States may operate as many CMS-approved HCBS waiver programs as they want. Currently, more than 300 HCBS waiver programs are in effect nationwide.

A State's HCBS waiver may include residential habilitation services, which are services designed to assist an individual with the acquisition, retention, or improvement of skills related to living in the community. Residential habilitation may be furnished in the individual's own home, the home of a relative, a semi-independent or supported apartment or living arrangement, or a group home.

Categories of Costs That We Reviewed in Previous Audits of Home and Community-Based Services Waiver Programs

HCBS waiver programs must comply with Federal requirements that exclude from Federal reimbursement a number of categories of costs and types of services, such as room-and-board costs, personal care services, and add-on services, and that pertain to State-level processes for approval of costs and development of payment rates to providers of services.

A State Medicaid agency may obtain a waiver that allows it to furnish an array of services to Medicaid recipients so that they can live in their communities and avoid institutionalization (section 1915(c) of the Act). Room-and-board¹ costs are generally not allowable under an HCBS waiver (42 CFR § 441.310(a)(2)). These costs are allowable, however, if they are part of respite care services in State-approved facilities that are not private residences or under waivers that allow personal caregivers to provide approved, designated services (42 CFR § 441.310(a)(2)).

HCBS waivers may also authorize personal care services that assist with activities of daily living, such as feeding and bathing. Personal care services may also include assistance with self-administered medications or administration of medications by a qualified personal care aide with the required training and certification. A waiver for personal care services must assure that providers of these services have met all State licensure or certification requirements (42 CFR § 441.302(a)(2)). States establish the specific licensure or certification requirements for the personal care service providers.

State Medicaid agencies pay providers a daily rate for each authorized recipient of services; this rate includes a component for the habilitation services themselves and a fee for associated administrative costs. The service component of a daily rate varies according to the recipient's individual plan of care² and the identified level of need. When the service component of the daily rate is insufficient to meet the requirements of the recipient's plan of care or when the recipient's condition changes, that individual may be eligible for add-on services (which are residential habilitation services provided in addition to those services covered under the per diem rate). In such cases, the HCBS waiver must specify the level of need at which the recipient can be approved for these services.

State Medicaid agency HCBS waivers may also include requirements for developing payment rates and for identifying review and approval mechanisms. These mechanisms sometimes divide responsibilities between State Medicaid agencies and one or more other executive branch departments of that State's government. For example, of the 10 HCBS waivers in effect in Missouri during State fiscal years (SFYs) 2011 through 2013 (July 1, 2010, through

¹ CMS's *State Medicaid Manual*, section 4442.3.B.12, defines "room" as hotel or shelter-type expenses, including all property-related costs (e.g., rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services) and defines "board" as three meals a day or any other full nutritional regimen.

² In general, an individual plan of care, also known as an individual service plan, is a document prepared by a case manager. Individualized in its scope, it identifies the client's goals, strengths, and needs, as well as the State-level services and programs that address those needs. Services identified in the individual service plan must, to the greatest extent possible, be consistent with the individual's preferences and be provided in the least restrictive setting.

June 30, 2013), 5 were operated by the Missouri Department of Mental Health (DMH), and 5 were operated by the Missouri Department of Health and Senior Services (DHSS). Although the Missouri Department of Social Services, Missouri HealthNet Division (Missouri), administered the State's Medicaid program, some of the HCBS waivers required Missouri to obtain approval from DMH or DHSS of the monthly budgets that each provider submitted for services rendered to program recipients. Missouri—that is, the State agency—then used the approved budget to determine the per diem payment rate for each recipient.

State Medicaid agencies must also ensure financial accountability for funds expended under the HCBS waiver program and make available to OIG the appropriate financial records documenting the costs of services provided under the HCBS waiver (42 CFR § 441.302(b)).

HOW WE CONDUCTED THIS REVIEW

We previously reviewed the Medicaid HCBS waiver programs at selected State agencies to determine whether those programs complied with Federal requirements; we summarize the results of those reviews for this report. We conducted these reviews at four State agencies using Medicaid claim data. Our earliest audit period for this series of reviews was for South Carolina (A-04-11-04012) (SFYs 2007 through 2009), with a followup report covering SFY 2010 (A-04-14-04019). Several other reports (A-03-13-00202, A-07-14-03201, A-07-14-03202) had audit periods ending in SFY 2013 (see Appendix A). Our eight audit reports on these reviews made recommendations to the four State agencies regarding unallowable and unsupported Medicaid reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards.³ 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.

Appendix B contains details of our audit scope and methodology, and Appendix C contains the Federal requirements applicable to the audits summarized in this report.

FINDINGS

In our eight previous audits, we identified instances in which State agencies did not always comply with Federal requirements in administering their HCBS waiver programs. Specifically, we found that the four State agencies (Maryland, New York, Missouri, and South Carolina) did not always exclude unallowable room-and-board costs when determining payment rates under

³ All of the previous audits (Appendix A) included in this rollup report were also conducted in accordance with generally accepted government auditing standards.

the HCBS waiver program, resulting in at least \$90,857,898 (Federal share) in unallowable Medicaid reimbursement.⁴

In addition, our previous reports conveyed the following other findings which, combined, resulted in a total of at least \$85,622,295 (Federal share) in unallowable and unsupported Medicaid reimbursement:

- Maryland did not always ensure that personal care services under the HCBS waiver program were provided by qualified personnel, supported by an approved plan of care, authorized, and properly documented, resulting in \$10,864,195 (Federal share) in unallowable Medicaid reimbursement;
- Maryland did not always provide add-on services only to beneficiaries who met the HCBS waiver’s level-of-need requirement for those services, resulting in \$34,155,857 (Federal share) in unallowable Medicaid reimbursement;
- Missouri did not always exclude unapproved costs when determining payment rates under the HCBS waiver program, resulting in \$1,455,378 (Federal share) in unallowable Medicaid reimbursement; and
- Missouri did not always ensure that all payment rates under the HCBS waiver program were properly supported and documented, resulting in \$39,146,865 (Federal share) for which we were unable to determine the allowability of Medicaid reimbursement.

The table on the following page summarizes the findings from our previous audits and totals, by State, the unallowable and unsupported Medicaid reimbursement resulting from the unallowable room-and-board costs and from the other unallowable and unsupported costs.

⁴ Some of the previous audits’ findings regarding unallowable room-and-board costs were based on statistically valid methodologies for sampling and projection. Our policy is to project or extrapolate costs to the lower limit of the 90-percent confidence interval, which produces a conservative estimate of questioned costs. Because actual disallowances may, through the audit resolution process, ultimately be higher, we qualify the dollar amounts of costs questioned through sampling and projection with the phrase “at least.”

Table: Unallowable and Unsupported Medicaid Reimbursement Resulting From Unallowable Room-and-Board Costs and Other Unallowable and Unsupported Costs Identified in Previous Audits of the Four State Agencies

State	Medicaid Reimbursement Resulting From Unallowable Room-and-Board Costs	Medicaid Reimbursement Resulting From Other Unallowable and Unsupported Costs	Total
Maryland	\$20,627,705	\$45,020,052	\$65,647,757
New York	60,763,536	0	60,763,536
Missouri	3,034,157	40,602,243	43,636,400
South Carolina	6,432,500	0	6,432,500
Total	\$90,857,898	\$85,622,295	\$176,480,193

The State agencies did not have adequate controls to ensure that their HCBS waiver programs complied with applicable Federal requirements regarding the need to exclude unallowable room-and-board costs when determining payment rates. In addition, Maryland and Missouri did not have adequate controls to ensure that certain other costs complied with the requirements associated with their HCBS waiver programs.

UNALLOWABLE MEDICAID REIMBURSEMENT RESULTING FROM UNALLOWABLE ROOM-AND-BOARD COSTS

The four State agencies did not comply with Federal requirements⁵ because they included unallowable room-and-board costs in the calculation of the payment rates for residential habilitation or group home habilitation services. As a result, the four State agencies claimed at least \$90,857,898 (Federal share) in unallowable Medicaid reimbursement.

The Maryland Department of Health and Mental Hygiene (Maryland) did not comply with Federal requirements when it claimed costs for residential habilitation services under its HCBS waiver. Maryland included unallowable costs for room and board in the calculation of the payment rate for residential habilitation services. As a result, Maryland claimed at least an estimated \$20,627,705 (Federal share) in unallowable Medicaid reimbursement.

The New York Department of Health (New York) did not comply with Federal requirements when it claimed costs for residential habilitation services under its HCBS waiver. New York included unallowable costs for room and board in the calculation of the payment rate for

⁵ 42 CFR § 441.310(a)(2).

residential habilitation services. As a result, New York claimed \$60,763,536 (Federal share) in unallowable Medicaid reimbursement.

Missouri did not comply with Federal requirements when it claimed costs for group home habilitation services under its HCBS waiver. Missouri included unallowable costs for room and board in the calculation of the payment rate for group home habilitation services. As a result, Missouri claimed \$3,034,157 (Federal share) in unallowable Medicaid reimbursement.

The South Carolina Department of Health and Human Services (South Carolina) did not comply with Federal requirements when it claimed costs for residential services under its HCBS waiver. South Carolina included unallowable costs for room and board in the payments for residential services. As a result, South Carolina claimed \$6,432,500 (Federal share) in unallowable Medicaid reimbursement.

UNALLOWABLE AND UNSUPPORTED MEDICAID REIMBURSEMENT RESULTING FROM OTHER UNALLOWABLE AND UNSUPPORTED COSTS

Two of the four State agencies reviewed in our previous audits did not comply with Federal requirements because they claimed unallowable Medicaid reimbursement for services under their HCBS waiver programs. As a result, the two State agencies claimed at least \$85,622,295 (Federal share) in unallowable and unsupported Medicaid reimbursement.

Personal Care Services Costs

Maryland did not comply with Federal and State requirements⁶ when it claimed Medicaid reimbursement for personal care services under its HCBS waiver. Maryland included unallowable costs for personal care services that were provided by unqualified personnel,⁷ unapproved or missing the plan of care, unauthorized, or undocumented. As a result, Maryland claimed \$10,864,195 (Federal share) in unallowable Medicaid reimbursement.

Add-on Services Costs

Maryland did not comply with Federal requirements⁸ when it claimed Medicaid reimbursement for add-on services under its HCBS waiver. Maryland included costs for add-on services for beneficiaries who did not meet the HCBS waiver's level-of-need requirement for those services. As a result, Maryland claimed \$34,155,857 (Federal share) in unallowable Medicaid reimbursement.

⁶ 42 CFR § 441.302(a)(2).

⁷ Maryland regulations require personal care aides to have current first aid and cardiopulmonary resuscitation certifications and a criminal background check (COMAR 10.09.54.06).

⁸ Maryland, *Community Pathways Home and Community-Based Waiver*, Appendix I, section 2(a).

Unapproved Costs

Missouri did not comply with Federal requirements when it claimed Medicaid reimbursement for individualized supported living (ISL) habilitation services under its HCBS waiver.⁹ Missouri included costs that DMH had not approved in some of its payment rates for ISL habilitation services. As a result, Missouri claimed \$1,455,378 (Federal share) in unallowable Medicaid reimbursement.

Unsupported Costs

Missouri did not comply with Federal requirements when it claimed Medicaid reimbursement for group home habilitation services under its HCBS waiver. Missouri could not provide supporting documentation for some of its payment rates. As a result, we were unable to determine the allowability of Medicaid reimbursement totaling \$39,146,865 (Federal share).¹⁰

INADEQUATE CONTROLS

Both the CMS *State Medicaid Manual*, chapter 4, sections 4440 through 4446, and the CMS HCBS Waiver Application provide guidance to the States regarding the administration of their HCBS waiver programs. Nevertheless, these four State agencies claimed the unallowable room-and-board costs summarized above because the State agencies did not have adequate controls to ensure that their HCBS waiver programs complied with applicable Federal requirements regarding the need to exclude these costs when determining payment rates. In addition, Maryland and Missouri did not have adequate controls to ensure that certain other costs complied with the requirements associated with their HCBS waiver programs.

SUMMARY OF UNALLOWABLE AND UNSUPPORTED MEDICAID REIMBURSEMENT RESULTING FROM UNALLOWABLE ROOM-AND-BOARD COSTS AND OTHER UNALLOWABLE AND UNSUPPORTED COSTS

As a result of the inadequate controls regarding unallowable room-and-board costs and certain other unallowable and unsupported costs, the State agencies claimed at least \$176,480,193 (Federal share) in unallowable and unsupported Federal Medicaid reimbursement for services under their HCBS waiver programs.

⁹ Missouri, *Home and Community-Based Services Waiver, Developmental Disabilities Comprehensive Waiver*, Appendix C and Appendix I, sections I-2 and I-5.

¹⁰ This finding was such that we did not and could not recommend, in our report to Missouri, that these funds be directly refunded to the Federal Government. Instead, we recommended that Missouri obtain supporting documentation from the group home providers, recalculate any payment rates that included room-and-board costs, and apply any recalculated payment rates to actual claims and refund any additional unallowable amount to the Federal Government.

RECOMMENDATIONS

We recommend that CMS:

- share the findings of our HCBS waiver program audits with all State agencies to reinforce Medicaid requirements that prohibit the inclusion of unallowable room-and-board costs when determining payment rates,
- share (at CMS's discretion) the other findings of our HCBS waiver program audits with all State agencies, and
- encourage all State agencies to review their procedures for calculating and claiming costs under their HCBS waiver programs.

CMS COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described actions that it had taken or planned to take.

CMS's comments are included in their entirety as Appendix D.

**APPENDIX A: PREVIOUSLY ISSUED
OFFICE OF INSPECTOR GENERAL REPORTS**

Report Title	Report Number	Date Issued
<i>Missouri Claimed Unallowable Medicaid Payments for Individualized Supported Living Habilitation Services</i>	<u>A-07-14-03202</u>	3/17/2016
<i>Missouri Claimed Unallowable and Unsupported Medicaid Payments for Group Home Habilitation Services</i>	<u>A-07-14-03201</u>	8/12/2015
<i>Maryland Claimed Unallowable Medicaid Costs for Residential Habilitation Add-on Services Under Its Community Pathways Waiver Program</i>	<u>A-03-13-00202</u>	6/29/2015
<i>South Carolina Claimed Some Unallowable Room-and-Board Costs Under the Intellectual and Related Disabilities Waiver for State Fiscal Year 2010</i>	<u>A-04-14-04019</u>	4/28/2015
<i>New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program</i>	<u>A-02-12-01031</u>	5/06/2014
<i>Maryland Claimed Costs for Unallowable Room and Board and Other Residential Habilitation Costs Under Its Community Pathways Waiver Program</i>	<u>A-03-12-00203</u>	9/09/2013
<i>Maryland Improperly Claimed Personal Care Services Provided Under Its Medicaid Home and Community-Based Services Waiver for Older Adults</i>	<u>A-03-11-00201</u>	4/11/2013
<i>South Carolina Claimed Some Unallowable Room-and-Board Costs Under the Intellectual and Related Disabilities Waiver</i>	<u>A-04-11-04012</u>	9/12/2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We previously reviewed the Medicaid HCBS waiver programs at selected State agencies to determine whether those programs complied with Federal requirements and are summarizing the results of those reviews for this report. We conducted these reviews at four State agencies using Medicaid claim data. Our previous audits covered various SFYs ranging from the beginning of SFY 2006 (July 1, 2006) through the end of SFY 2013 (June 30, 2013).

We conducted our fieldwork for our previous audits at four State agencies in Maryland, Missouri, New York, and South Carolina.

METHODOLOGY

To accomplish our objective, we analyzed the findings and recommendations from our eight previous audits. To accomplish our objectives in those previous audits, we:

- reviewed applicable Federal requirements,
- reviewed the CMS-approved HCBS waiver agreements applicable to each audit,
- held discussions with officials from the four State agencies to gain an understanding of their payment methodologies for the applicable HCBS waiver services,
- reviewed claim payment data for applicable HCBS waiver services,
- determined the Medicaid reimbursement for the applicable HCBS waiver services,
- removed unallowable costs for the applicable HCBS waiver services,
- calculated the unallowable Medicaid reimbursement for the applicable HCBS waiver services, and
- discussed the results of our reviews with the State agencies.

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.

APPENDIX C: FEDERAL REQUIREMENTS FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS

The principal criteria used in our previous reviews and for this report included the following Federal requirements:

Section 1915(c)(1) of the Act authorizes and allows payment for HCBS:

The Secretary [of Health and Human Services] may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State [Medicaid] plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

Section 1915(c)(4)(B) of the Act authorizes and allows payment for HCBS that are provided “consistent with written plans of care, which are subject to the approval of the State”

Federal regulations (42 CFR § 441.310(a)(2)) state that Federal reimbursement for HCBS is not available for expenditures for the cost of room and board except when provided as:

- (i) Part of respite care services in a facility approved by the State that is not a private residence; or
- (ii) For waivers that allow personal caregivers as providers of approved waiver services, a portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver beneficiary. FFP [Federal financial participation] for a live-in caregiver is not available if the beneficiary lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services (the caregiver). For purposes of this provision, “board” means 3 meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services as long as the meals provided do not constitute a “full” nutritional regimen.

Federal regulations (42 CFR § 440.2(b)) state: “FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart.”

Federal regulations (42 CFR § 440.180(a)(3)) state: “The services are subject to the limits on FFP described in § 441.310”

Federal regulations (42 CFR § 441.302) regarding State assurances for the HCBS waiver program state:

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

- (a) Health and Welfare—Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. Those safeguards must include—
 - (1) Adequate standards for all types of providers that provide services under the waiver;
 - (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver [Emphasis in original.]

Federal regulations (42 CFR § 441.302(b)) regarding financial accountability for the HCBS waiver program state: “The [State] agency will assure financial accountability for funds expended for home and community-based services ... and it will maintain and make available to HHS [the U.S. Department of Health and Human Services], the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver”

Application for a § 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide, and Review Guide, page 5, requires that a State must implement the waiver as specified in the approved application. If the State wants to change the waiver while it is in effect, it must submit an amendment to CMS for its review and approval.



APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: SEP 29 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program (A-07-16-03212)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to making sure that State Agencies claim appropriate payments for home and community-based services (HCBS).

HCBS programs provide opportunities for Medicaid beneficiaries to receive services in their own home or community, rather than in institutions. Some of our most vulnerable populations benefit from these services, such as people with mental illnesses, intellectual or developmental disabilities, physical disabilities and/or the elderly.

In 2014, CMS issued a final rule that set forth requirements for several Medicaid authorities under which States may provide home and community-based long-term services and supports. The regulations enhanced the quality of HCBS and provided additional protections to individuals that receive services under these Medicaid authorities.

Additionally, in 2014, CMS published a Quality Information Bulletin that modifies the quality assurance systems under § 1915(c) waivers. This included revisions to the financial accountability assurances and subassurances that the State must demonstrate in order for the State's waiver to be renewed. This includes assurances around the State's ability to demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program. In addition, the State must also demonstrate subassurances by providing evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. The State must also provide evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

CMS also provides regular technical assistance through a HCBS training series, including monthly State Operations and Technical Assistance (SOTA) webinars on a variety of HCBS topics. From February to September, CMS conducted six SOTA webinars focused solely on §1915(c) waiver rate setting methodologies and fiscal integrity processes. Topics have included and may continue to include: monitoring fraud, waste, and abuse in HCBS personal care services, rate setting methodology in a fee-for-service HCBS environment, increasing fiscal protections for HCBS personal care services, fee schedule HCBS rate setting demonstrations, and financial accountability of waivers, among other topics.

Further, in September, 2016 CMS posted four web-only presentations related to rate setting and fiscal integrity for §1915(c) waiver programs. Topics included transparent documentation of rate setting methodologies, use of inflation factors in rate setting, rate data validation methods, and methods for calculating estimates used to demonstrate cost neutrality.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Share the findings of our HCBS waiver program audits with all State agencies to reinforce Medicaid requirements that prohibit the inclusion of unallowable room-and-board costs when determining payment rates.

CMS Response

CMS concurs with OIG's recommendation. CMS can make the States aware of the final report, when issued; while noting that States may or may not be appealing these findings. In addition, CMS can include the findings from the report as part of a future SOTA webinar.

OIG Recommendation

Share (at CMS's discretion) the other findings of our HCBS waiver program audits with all State agencies.

CMS Response

CMS concurs with OIG's recommendation. CMS can make the States aware of the final report, when issued, while noting that States may or may not be appealing these findings. In addition, CMS can include the findings from the report as part of a future SOTA webinar.

OIG Recommendation

Encourage all State agencies to review their procedures for calculating and claiming costs under their HCBS waiver programs.

CMS Response

CMS concurs with OIG's recommendation. CMS continues to provide guidance to States on their procedures for calculating and claiming costs under their HCBS waiver programs. In particular, CMS continues to facilitate a HCBS training series, which included a recent SOTA webinar in March 2016 on "Rate Methodology in a FFS HCBS Structure." This was also presented at the annual HCBS Conference in August of 2015. In addition, as part of the 2014 Quality Information Bulletin, CMS added a subassurance under the financial accountability section that addresses rate methodology, with the expectation that the State would continue to report evidence that claims are coded and paid in accordance with the rate methodology specified in the approved waiver and another that requires the state on an annual basis to verify that the rate build is consistent with the CMS approved rate methodology.

CMS appreciates OIG's input and feedback on the issue of unallowable and unsupported Medicaid reimbursements for services claimed by State Agencies under HCBS. We look forward to continue working with OIG on this issue and others in the future.