Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSOURI CLAIMED SOME UNALLOWABLE MEDICAID PAYMENTS FOR TARGETED CASE MANAGEMENT SERVICES

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Office of Inspector General

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Report in Brief
Date: March 2019
Report No. A-07-17-03219

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Missouri Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services

Why OIG Did This Review

Targeted Case Management (TCM) services assist specific State-designated Medicaid groups in gaining access to medical, social, educational, and other types of services. Previous OIG reviews found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

Our objective was to determine whether Missouri claimed Federal Medicaid reimbursement for TCM services during Federal fiscal years (FYs) 2014 and 2015 in accordance with Federal and State requirements.

How OIG Did This Review

We reviewed documentation for 155 randomly selected TCM paid claims from the developmental disability target group (Missouri's largest target group for TCM services) to determine whether the services provided were allowable, case managers providing services were qualified to do so, and recipients receiving services were eligible. We also reviewed payment rates to determine whether they matched the established fee schedule for the period.

Our review compared TCM claims documentation provided by Missouri to applicable Federal regulations and the State plan supplement governing Missouri's TCM program.

What OIG Found

Missouri claimed Federal Medicaid reimbursement of at least $6 million (almost $3.8 million Federal share) for unallowable TCM payments during FYs 2014 and 2015. Missouri paid TCM providers and claimed unallowable Federal Medicaid reimbursement because its policies and procedures did not ensure that those providers complied with Federal and State requirements for documenting case managers' qualifications and for documenting and claiming TCM services. In addition, Missouri did not have policies and procedures to ensure that it correctly reported, in its claims for Federal Medicaid reimbursement, TCM paid claims it had recouped from a TCM provider.

Of the 155 randomly sampled TCM claims we reviewed, 21 claims had at least 1 error related to provider qualifications (13 claims), unallowable services (6 claims), unsupported services (2 claims), or TCM paid claims that Missouri had recouped but which it incorrectly accounted for when claiming Federal reimbursement (3 claims). (Some claims had more than one error.)

What OIG Recommends and Missouri Comments

We recommend that Missouri refund the almost $3.8 million to the Federal Government for unallowable TCM claims. We also make procedural recommendations to Missouri that it strengthen its policies and procedures (1) to ensure that TCM providers maintain documentation of case manager qualifications and to support the TCM services provided and (2) to ensure that Missouri does not pay TCM providers or claim Federal reimbursement for services that are not TCM services and correctly reports recoupment of TCM claims from providers.

Our draft report had identified 23 TCM claims with errors. Missouri disagreed with all but two of the claims that we had found to be unallowable, saying that these were allowable expenditures consistent with Federal and State law and policy. Missouri provided additional documentation with its comments on our draft report.

After reviewing Missouri's comments and the additional documentation, we revised, for this final report, the number of sampled claims in error that we identified, from 23 to 21 claims. Accordingly, we revised our statistical estimate and the dollar amount conveyed in our first recommendation. We maintain that our findings and recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Case management services assist Medicaid recipients in gaining access to medical, social, educational, and other types of services. When these services are furnished to one or more specific populations within a State, they are known as Targeted Case Management (TCM) services. During Federal fiscal years (FYs) 2014 and 2015, the Missouri Department of Social Services (State agency) claimed $131.7 million ($82.6 million Federal share) for TCM services. Previous Office of Inspector General reviews (Appendix B) found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for TCM services during FYs 2014 and 2015 in accordance with Federal and State requirements.

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, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the CMS-64 report and its attachments must be actual expenditures with supporting documentation. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During our audit period, Missouri's FMAP ranged from 62.03 percent to 63.45 percent.

Medicaid Coverage of Targeted Case Management Services

The Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid recipients (§ 1905(a)(19)). Furthermore, the Act defines case management services as "services that will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services" (§ 1915(g)(2)).

Federal regulations (42 CFR § 440.169(b)) refer to case management services as TCM services when they are furnished to specific populations in a State. Federal regulations state that allowable TCM services include assessment of an individual to determine service needs, development of a specific care plan, referral and related activities to help the individual obtain needed services, and monitoring and followup activities (42 CFR § 440.169(d)). However, Federal regulations also state that TCM services do not include the direct delivery of the underlying medical, educational, social, or other services to which the Medicaid-eligible individual has been referred, including services such as providing transportation (42 CFR § 441.18(c)).

The CMS *State Medicaid Manual* states that FFP is not available for the specific services needed by an individual as identified through case management activities unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred (CMS *State Medicaid Manual* § 4302.2(G)(1)).

Missouri Medicaid Program and Targeted Case Management

In Missouri, the State agency administers the provision and payment of Medicaid services. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The Missouri State plan includes a Supplement that addresses the provision of TCM services (TCM State plan supplement) and that designates three target groups to receive TCM services:

- persons with one or more developmental disabilities,
- individuals, 16 and over, suffering from chronic mental illness, and
- children and youth under 18 years of age who are severely emotionally disturbed.

For each target group, the TCM State plan supplement contains information about, among other things, case management provider qualifications, allowable TCM services, and recipient eligibility requirements.

In general, the State agency receives bills for TCM services from Medicaid providers, reviews and pays those bills, and claims Federal reimbursement on the CMS-64 reports. More

specifically, TCM services for adults with chronic mental illness and children who are severely emotionally disturbed are billed using a 15-minute unit of service, while TCM services for the developmental disability target group are billed using a 5-minute unit of service.

The State agency's TCM payment rates are based on a fee schedule and vary by the type of TCM service being performed as well as the education level of the Case Manager performing the service. The State agency can, with CMS's approval, increase the payment rates periodically by amounts commensurate with the rate of inflation.

Targeted Case Management Services to Individuals With Developmental Disabilities

The State agency provides TCM services to the developmental disability target group through several different types of entities: regional offices of the Missouri Division of Developmental Disabilities, County Senate Bill 40 Boards, Affiliated Community Service Providers (ACSPs), and not-for-profit agencies registered with the Missouri Secretary of State. Because, as discussed just below, TCM services provided to the developmental disability target group represent the vast majority of the TCM claims for our audit period, we refer to the above-named entities for this report as "TCM providers."

HOW WE CONDUCTED THIS REVIEW

We reviewed a stratified random sample totaling 155 TCM paid claims from the developmental disability target group.[1] This target group represented over 98 percent of all TCM claims in Missouri in FYs 2014 and 2015.[2] We obtained and reviewed documentation for each TCM service provided to determine whether the claims complied with applicable Federal and State requirements.

We obtained and reviewed case notes that documented the services provided, recipient eligibility documentation, and provider qualifications to determine whether the TCM services provided and paid for complied with Federal and State requirements. We also compared the rates paid to the payment rates that CMS approved for the month in which services were rendered.

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.

[1] A claim encompasses all TCM services provided by a TCM provider to a single Medicaid recipient for a single month. A claim may therefore include multiple TCM activities and case managers.

[2] The audit period encompassed the most current data available at the time we initiated our review.

Appendix A contains details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, Appendix E contains details on the Federal and State requirements related to TCM, and Appendix F summarizes the errors for each sampled claim.

FINDINGS

During FYs 2014 and 2015, the State agency claimed Federal Medicaid reimbursement for some TCM services that did not comply with Federal and State requirements. Specifically, 21 of the 155 randomly sampled TCM claims were unallowable because they had at least 1 of the following errors (some claims had more than 1 error):

- the TCM providers could not provide documentation supporting that the case managers had the qualifications—that is, the education or experience—required by the TCM State plan supplement (13 claims);

- the TCM providers' case notes lacked sufficient detail to support that claimed services were allowable (6 claims);

- the TCM providers could not provide documentation to support that they had actually provided 1 or more TCM services to the Medicaid recipients (2 claims); and

- the State agency did not correctly account on its CMS-64 reports for TCM paid claims it had recouped from a TCM provider (3 claims).

Although these TCM claims had errors, the State agency paid the TCM providers and then claimed Federal Medicaid reimbursement for them.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $6,042,118 ($3,781,709 Federal share) in unallowable Medicaid reimbursement for TCM services during FYs 2014 and 2015.

The State agency incorrectly paid TCM providers and claimed unallowable Federal Medicaid reimbursement because its policies and procedures did not ensure that those providers complied with Federal and State requirements for documenting case managers' qualifications and for documenting and claiming TCM services. In addition, the State agency did not have policies and procedures to ensure that it correctly reported recoupments on the CMS-64 reports.

THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE CLAIMS

During FYs 2014 and 2015, the State agency claimed Federal Medicaid reimbursement for some TCM claims that did not comply with Federal and State requirements. Of the 155 randomly

sampled TCM claims we reviewed, 21 were unallowable for Medicaid reimbursement (some claims had more than 1 error).

Federal and State Requirements

Federal regulations define the types of services that are allowable and unallowable as TCM services and specify the requirements for maintaining supporting documentation (42 CFR §§ 440.169(d) and 441.18). The TCM State plan supplement defines the target population for each group, the types of services available to the target population, and the requirements for providers and case managers (Missouri State Plan, Supplement 1 to Attachment 3.1-A).

Targeted Case Management Providers Could Not Provide Documentation for Case Managers' Qualifications

Federal regulations state that provider qualifications should be reasonably related to the population being served and the case management services furnished (42 CFR § 441.18 (a)(8)(v)). The TCM State plan supplement requires that individuals who provide TCM services have, at a minimum, 1 or more years of professional experience (a) as a registered nurse, (b) in social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, or a closely related area, or (c) in providing direct care to persons who have developmental disabilities. The TCM State plan supplement also requires that these individuals have a bachelor's-level degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in 1 of, or a combination of, human service field specialties. Additional experience as a registered nurse may substitute on a year-for-year basis for a maximum of 2 years of required education (Missouri State Plan, Supplement 1 to Attachment 3.1-A, page 4d).

The State agency claimed unallowable Federal Medicaid reimbursement for 13 TCM claims, in each of which at least 1 case manager who did not meet these qualifications had provided TCM services for which the TCM provider then billed the State agency.[3] Specifically, we identified (1) individuals who lacked the required education, experience, or both and (2) individuals for whom the State agency could provide no documentation of education or experience for us to review.

Providers Lacked Documentation To Support That Targeted Case Management Services Were Allowable

Federal regulations state that providers must maintain case notes that document, for all individuals receiving case management, the nature, content, and units of the case management services received and whether goals specified in the care plan have been achieved (42 CFR § 441.18(a)(7)(iv)). In addition, case management services refer to services furnished to assist

[3] In those instances in which more than one case manager had billed TCM services for a claim, we considered only the units billed by the unqualified case manager(s) when calculating our unallowable amount.

individuals, eligible under the State plan, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services (42 CFR § 440.169 (a)). The TCM State plan supplement requires case documentation be completed which includes progress notes (case notes) (Missouri State Plan, Supplement 1 to Attachment 3.1-A, page 3d).

The State agency claimed unallowable Federal Medicaid reimbursement for six claims in which case notes lacked sufficient detail to support that the services performed were allowable in accordance with Federal requirements, the TCM State plan supplement, or both.

For example, for a TCM provider's bill with 83 units of service, the State agency paid the provider, then claimed the 83 units for Federal reimbursement. However, 9 of the 83 units that the TCM provider billed (regarding the provision of a special needs stroller) identified a different Medicaid recipient than was identified in the associated case note for these units of service. We could find no correlation between the Medicaid recipient identified in the case note and the Medicaid recipient for whom these units of service were billed.

Providers Did Not Maintain Documentation To Support Targeted Case Management Claims

A State plan is required to "provide for agreements with every person or institution providing services under which such person or institution agrees (A) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan and (B) to furnish the State agency or the Secretary [of Health and Human Services] with such information . . . as the State agency or the Secretary may from time to time request" (the Act § 1902(a)(27)).

For two claims, the TCM provider did not maintain documentation to support that it had actually provided a TCM service to a Medicaid recipient. Specifically, the TCM provider did not provide the case notes related to the TCM service that the provider billed and that the State agency paid (and then claimed for Federal reimbursement).

State Agency Did Not Correctly Account on the CMS-64 Reports for Targeted Case Management Paid Claims It Had Recouped

The CMS *State Medicaid Manual* states that FFP is available at the FMAP rate for allowable case management services in which payment for services is made following the receipt of the valid provider claim (CMS *State Medicaid Manual* § 4302.2(G)(1)).

For three claims, the State agency did not correctly account for the recoupment of TCM paid claims on the CMS-64 reports that it used to claim Federal Medicaid reimbursement. Specifically, the State agency paid one TCM provider for three claims at an incorrect rate. After identifying these errors, the State agency took steps to correct them by recouping the original payment from the TCM provider and then paying the provider at the correct rate. However, in

the MMIS claims data the State agency did not correctly account for the recoupment (that is, the recouped amount was reported as $0 instead of the correct amount, which was a negative adjustment in the amount of $25.05). As a result of incorrectly accounting for these paid claims it had recouped, the State agency reported on the CMS-64 reports, and claimed Federal Medicaid reimbursement for, TCM paid claims that were not eligible for FFP.

Table 1 below is an example of the claim lines detail for one of the claims in error that is described above.

Table 1: Recoupment of TCM Paid Claim

Claim Line	Date of Service	Paid Date	Units	Paid Amount
Original Payment	8/9/2014	9/19/2014	3	$25.05
Recoupment	8/9/2014	7/6/2015	-3	$ 0.00
New Payment	8/9/2014	7/17/2015	3	$25.20

Effect of Unallowable Targeted Case Management Claims

Although the TCM claims had the errors described above, the State agency paid the TCM providers and then claimed Federal Medicaid reimbursement for them.

On the basis of our sample results, we estimated that the State agency paid TCM providers and then improperly claimed at least $6,042,118 ($3,781,709 Federal share) in Federal Medicaid reimbursement for 354,626 TCM claims during FYs 2014 and 2015.

THE STATE AGENCY'S POLICIES AND PROCEDURES DID NOT ENSURE COMPLIANCE WITH FEDERAL AND STATE REQUIREMENTS

The State agency incorrectly paid TCM providers and claimed unallowable Federal Medicaid reimbursement because its policies and procedures did not ensure that those providers complied with Federal and State requirements for documenting case managers' qualifications and for documenting and claiming TCM services. In addition, the State agency did not have policies and procedures to ensure that it correctly reported recoupments on the CMS-64 reports.

RECOMMENDATIONS

We recommend that the State agency:

- refund $3,781,709 to the Federal Government for unallowable TCM claims; and

- strengthen its policies and procedures to ensure that:

    - TCM providers maintain documentation to document that case managers are qualified to perform TCM services,

    - TCM providers maintain documentation to support the TCM services provided,

    - it does not pay TCM providers or claim Federal reimbursement for services that are not TCM services, and

    - it correctly reports recoupment of TCM claims from TCM providers on its CMS-64 reports.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with all but two of the TCM claims that we had found to be unallowable. The State agency also disagreed with the draft report's first recommendation to refund $3,991,093 to the Federal Government. The State agency said that

> the overwhelming majority of the items questioned by the Draft Audit Report were allowable expenditures consistent with state and federal law and policy. In addition, the disallowance recommendation is based on an extrapolation to the entire audit period of the [Office of Inspector General's] conclusion that the federal funds claimed in the sample were unallowable. Extrapolating a disallowance based on isolated errors in complying with documentation rules is inappropriate and inconsistent with federal policies.

The State agency neither agreed nor disagreed with our second recommendation but stated that it would continue to work to comply with Federal requirements in providing and claiming TCM services.

A summary of the State agency's comments (which refer from time to time to case notes and other additional documentation separately provided to us) and our responses follows. The State agency's comments, in which we have redacted personally identifiable information and from which we have removed voluminous attachments, appear as Appendix G. We are separately providing the State agency's comments and attachments in their entirety to CMS.

After reviewing the State agency's comments and the additional documentation that the State agency provided, we revised, for this final report, the number of sampled claims in error that we identified, from 23 to 21 claims. Accordingly, we revised our statistical estimate and the dollar amount conveyed in our first recommendation. We maintain that our findings and first recommendation, as revised, are valid. We also maintain that our second recommendation, regarding the State agency's administration of its TCM program, remains valid.

CLAIMS INVOLVING DOCUMENTATION OF CASE MANAGER QUALIFICATIONS

State Agency Comments

The State agency cited the relevant provisions of the TCM State plan supplement and stated that for 13 of the 14 claims disallowed in the draft report, the State of Missouri, Department of Mental Health (DMH), had concluded that the case managers' qualifications met all of the State plan requirements.[4] The State agency also said that "[t]he State is entitled to deference in its interpretation of the State Plan, including the definition of the 'human service field' and the courses which qualify as human services" and, quoting case law, added, "'so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and applicable federal requirements.'"

With respect to the 13 claims that we disallowed, the State agency described our findings as "based on incorrect factual findings about the case manager's qualifications and/or a narrow interpretation of coursework in 'human service field specialties' that differs from DMH's own reasonable interpretation."

The State agency separately provided transcripts, resumes, and other additional documentation that, it said, supported the case managers' qualifications. In addition, during our fieldwork the State agency provided a definition of the "human services field," taken from CMS guidance, which states: "[h]uman services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves."

For the other claim (of the 14), the State agency agreed that the case manager in question did not have the required experience. The State agency said that it would refund the unallowable amount associated with this claim, but not the extrapolated amount.

Office of Inspector General Response

The additional documentation that the State agency gave us resolved 1 of the 14 claims that our draft report had identified as unallowable. We therefore reduced the number of claims associated with this finding, from 14 to 13, and adjusted the associated statistical estimate, as well as the dollar amount in our first recommendation, accordingly. Of the remaining 13 claims in this finding, the State agency agreed with us on 1 claim. For the other 12 claims, most of the additional documentation had previously been given to us by the State agency during our fieldwork; these documents did not support that the case managers met the required qualifications.

[4] We summarize the relevant provisions of the TCM State plan supplement at the end of Appendix E of this report. In Missouri, DMH is a sister agency to the State agency; with respect to TCM case managers, DMH reviewed the documentation and determined that the case managers met all of the State plan requirements.

Although we agree that the State agency is entitled to deference in its interpretation of the State plan and applicable Federal requirements, that interpretation must be reasonable. Most of the errors, in fact, resulted not from a disagreement between our and the State agency's interpretations of requirements, but instead from a lack of documentation. Specifically, the errors that remained in these 12 claims involved the facts that the State agency did not provide transcripts to support the educational requirements (4 claims), the documentation did not support the 1 year of experience required by the State plan (7 claims), or the documentation did not support the required 24 hours in the human services field (2 claims).

For these latter two claims, we accorded the State agency considerable deference, for instance, when we reviewed case managers' transcripts for the 24 semester hours in the "human services field" mandated by the TCM State plan supplement. In this context, we accepted any coursework that had an applicability to social services that, to use the CMS definition that the State agency had given us, "focused on improving the quality of life of clients." Accordingly, we accepted, as reasonable interpretations of State and Federal requirements, semester hours for coursework in fitness and wellness, personal and environmental health, and applied nutrition.

In contrast, the State agency's acceptance of the coursework that we did not accept did not constitute reasonable interpretations of the State plan and applicable Federal requirements. The two claims that we disallowed for not meeting the minimum 24-hour "human services field" educational requirement were for the same case manager. For this case manager, the State agency counted artcraft fundamentals[5] and fundamentals of music 1[6] as human services hours that contributed to the required 24 hours. We determined that basic art and music courses did not reflect a reasonable interpretation of the "human services field" and did not have an applicability to social services.

CLAIMS INVOLVING DOCUMENTATION TO SUPPORT THAT TARGETED CASE MANAGEMENT SERVICES WERE ALLOWABLE

State Agency Comments

The State agency cited Federal and State documentation requirements and disagreed that the seven claims disallowed in the draft report lacked sufficient detail to support that the claimed services were allowable in accordance with Federal requirements, the State plan, or both. The State agency described the services and activities recorded in the case manager's notes for each of these seven claims and added that for two claims, an allowable TCM service was noted on the incorrect beneficiary's case log. In addition, the State agency asked that for two other claims with a total of six service dates, we provide additional detail as to why we believe the services in question were unallowable.

[5] We were unable to find the actual course description, but based on the information we found on the university's website, this is a basic-level, introductory art course.

[6] The course description for Fundamentals of Music 1 was "Introduction to rhythmic, melodic, harmonic, and structural elements of music."

Office of Inspector General Response

We reviewed the additional documentation the State agency provided and determined that the additional documentation resolved one of the seven claims we had identified. We therefore reduced the number of claims associated with this finding, from seven to six, and adjusted the associated statistical estimate, as well as the dollar amount in our first recommendation, accordingly. For the other six claims, most of the additional documentation had previously been given to us by the State agency during our fieldwork. One of the errors that remained in these six claims involved (as discussed in our finding) a case note that (1) documented an individual who was not the Medicaid recipient for which the services were billed and paid for and (2) did not reflect any correlation between the individual and the Medicaid recipient (2 claims). Other errors in these remaining claims involved services provided that were not allowable TCM services (shopping and picking up money) (3 claims) as well as duplicate case notes (1 claim).

CLAIMS INVOLVING DOCUMENTATION TO SUPPORT TARGETED CASE MANAGEMENT SERVICES CLAIMS

State Agency Comments

The State agency cited Federal requirements for record retention and disagreed that the two claims disallowed in the draft report were unallowable. For the first of these two claims, the State agency said that service coordinators are allowed to claim transportation from a TCM service. The State agency added that the case notes did not state that the beneficiary was in the coordinator's vehicle, and therefore this was not a direct transportation service. For the second claim, the State agency cited a comment it said was in our draft report (involving "two erroneously billed units" of service) and asked for clarification.

Office of Inspector General Response

We disagree that these two claims were allowable. For the first of them, we determined that transportation of the Medicaid recipient was in fact involved. Specifically, the case note stated: "[Medicaid recipient] and an ISL [Individualized Supported Living] staff accompanied the [service coordinator] to [city] on [date] to tour the ISL the provider had chosen for [Medicaid recipient]." Federal requirements state that direct transportation of a Medicaid recipient is unallowable for Federal reimbursement as a TCM service. In addition, the TCM provider billed and was paid for 896 units; however, the case notes supported only 892 units. For the second claim in this finding, the TCM provider billed and was reimbursed for 366 units; however, the case notes supported only 364 units. We disallowed only the two unsupported units (the "two erroneously billed units" of service) associated with this claim.[7]

[7] The State agency's comments (ninth page of Appendix G) ascribe this quoted phrase, within a longer passage of quoted text, to our draft report. The language in question actually appears in material we provided separately to the State agency.

CORRECT ACCOUNTING OF RECOUPED TARGETED CASE MANAGEMENT CLAIMS

State Agency Comments

The State agency disagreed with our finding that it did not correctly account for the recoupment of three paid TCM claims on the appropriate CMS-64 reports. In addition, the State agency provided a spreadsheet that summarized the data pulled from the State agency's MMIS claims data and that, according to the State agency, showed that the State agency properly accounted for the recoupments in the MMIS data.

Office of Inspector General Response

The spreadsheet that the State agency gave us was in fact the original spreadsheet that we provided to the State agency during our fieldwork; it showed the recoupment amount of $0. This spreadsheet contained the comments and notations that we made when providing the claims information to the State agency. The State agency's only change was in the recoupment amount in the spreadsheet that we gave it (from $0 to -$25.05 in our example (Table 1)). The State agency has therefore not given us any additional documentation to show that it correctly reported and accounted for the recoupments on the CMS-64 reports.

PERCENTAGE OF TARGETED CASE MANAGEMENT CLAIMS SAMPLED

State Agency Comments

The State agency stated that we should have sampled from 100 percent, not 98 percent, of all TCM claims in Missouri during our audit period.

Office of Inspector General Response

We determined during our audit that the TCM claims paid by the State agency were concentrated in a single target group (i.e., the developmental disability target group).[8] This target group comprised over 98 percent of the State agency's total paid TCM claims for the audit period; thus we made an entirely justifiable audit decision to include only those claims in the sampling frame.

[8] See the discussion in "Targeted Case Management Services to Individuals With Developmental Disabilities" earlier in this report, as well as the discussion in the "Sampling Frame" section of Appendix C.

USE OF EXTRAPOLATION IN ESTIMATING UNALLOWABLE CLAIMS AND RECOMMENDED DISALLOWANCE

State Agency Comments

The State agency disagreed with our use of extrapolation to estimate the recommended refund and stated that "[j]ust because [the State agency] does not have all of the requisite documentation does not mean the entirety of each claims should be invalid and extrapolated to all other claims." In addition, the State agency said that most of our findings were not sufficiently serious or material to justify recoupment. The State agency also cited contract case law and stated:

> If the claim does not violate the rules in a manner that suggests the services were invalid or provided to an ineligible beneficiary, or delivered in an unsafe manner, the noncompliance will not have caused any harm to the federal government. The federal government will have received what it paid for, and a refund of federal dollars will be inappropriate, just as actual damages would be inappropriate for a non-breaching party left unharmed by a breach of contract.

Referring to its comments (summarized above) on the claims that our draft report had identified as unallowable, the State agency said that we should have rejected only 2 of the 155 sampled claims, which would equate to an error rate of 1.3 percent. The State agency added: "[t]his error rate is lower than the error tolerance levels established by various quality control programs in Medicaid and other federally funded programs . . . (establishing a 3 percent tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program."

Lastly, the State agency said that we "should not be able to sample from one subset of claims, and extrapolate those findings to a different pool of claims."

Office of Inspector General Response

In no case did we recommend disallowance of an entire claim. With respect to our findings, we disallowed only the portion of each paid TCM claim relating to the unallowable units of service (footnote 3). We disagree with the State agency's characterization of our findings as not sufficiently serious or material to justify recoupment to the Federal Government. As our findings point out, the disallowed claims reflected (1) case managers who were not qualified to provide TCM services; (2) case notes that did not document that an allowable TCM service had been performed; (3) TCM services that were billed and paid for but that lacked supporting case notes; and (4) recoupments that the State agency did not correctly report on the CMS-64 reports, which resulted in overclaims of TCM services for Federal reimbursement.

Furthermore, the 1.3 percent error rate that the State agency cited is applicable only in the context of the number of claims—two—for which the State agency agreed with our draft report's findings. We contend, though, that the number of sampled claims with errors was

not 2, but 21. On that basis, and using the same formula but a different numerator (21 sampled claims in error divided by the total of 155 sampled claims), the error rate is 13.55 percent. This rate is significantly higher than the error tolerance levels to which the State agency referred in its comments.

With respect to the State agency's final comment on this topic, we did not extrapolate the results of the sampled claims to a different pool of claims. As discussed in Appendix C, the sampling frame consisted of claims for the developmental disability target group, from which we drew the 155 sampled claims. We extrapolated the results of the sample to the sampling frame only (i.e., the developmental disability target group), which was the same pool of claims.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $131,708,575 ($82,576,770 Federal share) in Medicaid payments for TCM services provided and paid for in Missouri during FYs 2014 and 2015 (October 1, 2013, through September 30, 2015).

We reviewed a stratified random sample totaling 155 TCM paid claims from the developmental disability target group.[9] This target group represented over 98 percent of all TCM claims in Missouri in FYs 2014 and 2015. We obtained and reviewed documentation for each TCM service provided to determine whether the claims complied with applicable Federal and State requirements.

We did not assess the overall internal controls structure of the State agency or the Medicaid program. Rather, we limited our review of the internal controls to those applicable to our audit objective.

We conducted our audit work, which included fieldwork at the State agency in Jefferson City, Missouri, from February 2017 to April 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, Federal and State regulations, and the State plan and TCM State plan supplement;
- held discussions with State agency officials to gain an understanding of the operation of the TCM program;
- obtained the MMIS claim payment data for TCM services provided and paid for in FYs 2014 and 2015;
- reconciled the MMIS claims payment data for TCM services to the Medicaid payments that the State agency claimed on the CMS-64 reports for FYs 2014 and 2015;
- developed a sampling frame of MMIS claims provided and paid for during FYs 2014 and 2015 and consisting of 354,626 unique TCM paid claims;

[9] A claim encompasses all TCM services provided by a TCM provider to a single Medicaid recipient for a single month. A claim may therefore include multiple TCM activities and case managers.

- selected a stratified random sample of 155 TCM paid claims and reviewed supporting documentation for each of these to:

    - determine whether the TCM service(s) provided were allowable according to the TCM State plan supplement and whether the unit(s) charged were reasonable,

    - determine whether the recipient was eligible for TCM services,

    - determine whether the TCM provider was qualified to provide TCM services, and

    - determine whether the payment rate(s) paid were accurate;

- used the results of the sample to estimate (Appendix C) the unallowable Federal Medicaid reimbursement associated with the errors we identified (for which we are recommending refund to the Federal Government); and

- discussed the results of our audit with State agency officials on April 10, 2018.

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 B: PREVIOUSLY ISSUED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Colorado Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services	A-07-16-03215	4/4/2018
North Dakota Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services	A-07-16-03210	10/27/2016
Connecticut Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Chronic Mental Illness	A-01-14-00001	8/7/2015
Missouri Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Developmental Disabilities	A-07-13-03193	10/30/2014
Iowa Medicaid Payments for Targeted Case Management for Fiscal Years 2003 and 2004	A-07-06-03078	11/7/2007
Review of Minnesota Medicaid Reimbursement for Targeted Case Management Services for Fiscal Years 2003 and 2004	A-05-05-00059	10/15/2007
Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003	A-01-05-00004	12/4/2007
Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003	A-01-04-00006	5/16/2006

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of unique TCM paid claims with positive Medicaid reimbursements for TCM services that the State agency provided and paid for during FYs 2014 and 2015 (October 1, 2013, through September 30, 2015).

SAMPLING FRAME

The sampling frame consisted of 354,626 unique TCM paid claims from only the developmental disability target group. The reimbursement amount associated with these 354,626 claims totaled $131,708,575 ($82,576,770 Federal share) for our audit period.

SAMPLE UNIT

The sample unit was one TCM paid claim (footnote 1).

SAMPLE DESIGN

We used a stratified sample consisting of four strata. We divided the strata based on total Federal reimbursement amounts for the audit period, as shown in Table 2 below.

Table 2: Division of Strata for Sample Design

Stratum	Sample Units	Total Paid	Total Federal Share Paid Amount	Low Federal Share Paid Amount	High Federal Share Paid Amount
One	228,042	$40,331,387	$25,284,806	$30.00	$224.99
Two	91,140	$48,055,283	$30,126,655	$225.00	$499.99
Three	35,439	$43,284,903	$27,142,263	$500.00	$3,824.99
Four	5	$37,002	$23,046	$3825.00	$6,000.00
Totals	**354,626**	**$131,708,575**	**$82,576,770**		

SAMPLE SIZE

We selected 155 unique TCM paid claims: 50 from strata one through three, and 5 from stratum four.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software (RAT-STATS).

METHOD FOR SELECTING SAMPLE ITEMS

For each of strata one through three, we consecutively numbered the sample units. After generating the random numbers for each stratum, we selected the corresponding sample units in each stratum. For stratum four, we selected all five of the highest TCM paid claims.

ESTIMATION METHODOLOGY

We used RAT-STATS Variable Appraisal for stratified samples to estimate the amount of unallowable payment for TCM services.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Unallowable Claims Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
Stratum 1	228,042	$40,331,387	50	$8,801	4	$587
Stratum 2	91,140	$48,055,283	50	$25,752	5	$1,503
Stratum 3	35,439	$43,284,903	50	$60,847	9	$8,544
Stratum 4	5	$37,002	5	$37,002	3	$8,158
Total	**354,626**	**$131,708,575**	**155**	**$132,402**	**21**	**$18,792**

Table 4: Federal Share Unallowable Claims Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
Stratum 1	228,042	$25,284,806	50	$5,503	4	$371
Stratum 2	91,140	$30,126,655	50	$16,174	5	$932
Stratum 3	35,439	$27,142,263	50	$38,240	9	$5,386
Stratum 4	5	$23,046	5	$23,046	3	5,060
Total	**354,626**	**$82,576,770**	**155**	**$82,963**	**21**	**$11,749**

Table 5: Estimated Value of Unallowable Claims (Limits Calculated for a 90-Percent Confidence Interval)

	Total	Federal Share
Point estimate	$11,482,232	$7,213,229
Lower limit	$6,042,118	$3,781,709
Upper limit	$16,922,345	$10,644,749

APPENDIX E: FEDERAL AND STATE REQUIREMENTS FOR TARGETED CASE MANAGEMENT

FEDERAL REQUIREMENTS

Federal regulations (42 CFR §§ 440.169(a) and (b)) define TCM services as services furnished to assist individuals, eligible under the State plan, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

Federal regulations (42 CFR § 440.169(d)) state that the assistance that TCM case managers provide in assisting eligible individuals to obtain services includes:

> (1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. . . .
>
> (2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment. . . .
>
> (3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
>
> (4) Monitoring and followup activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring. . . .

Federal regulations require TCM providers to maintain case records that document, for all individuals receiving TCM services, "[t]he nature, content, units of the [TCM] services received and whether goals specified in the care plan have been achieved" (42 CFR § 441.18(a)(7)(iv)).

Federal regulations state that TCM "does not include, and FFP is not available in expenditures for, services defined in § 441.169 of this chapter when the [TCM] activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for services such as, but not limited to," providing transportation (42 CFR § 441.18(c)).

The CMS *State Medicaid Manual* states that FFP is not available for the specific services needed by an individual as identified through case management activities unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of

the services or programs to which recipients are referred (CMS *State Medicaid Manual* §§ 4302.2(G)(1) and (2)).

STATE REQUIREMENTS

The TCM State plan supplement defines the developmental disability target group as being comprised of Medicaid recipients who have been determined by the State agency to have a developmental disability as defined in 9 Code of State Regulations 45-2.010 (Missouri State Plan, Supplement 1 to Attachment 3.1-A, page 1d).

The TCM State plan supplement's definition of TCM services closely mirrors the definition of TCM services set forth in 42 CFR § 440.169. The State plan language defines TCM as services that assist eligible individuals in gaining access to needed medical, social, educational, and other services. The State plan language further breaks out services into the categories of assessment, planning for services, case coordination, monitoring, and documentation (Missouri State Plan, Supplement 1 to Attachment 3.1-A, pages 2d – 3d).

The TCM State plan supplement requires that those individuals who provide TCM services have, at a minimum, a bachelor's-level degree of education with a minimum of 24 semester hours in 1 of, or a combination of, human service field specialties. In addition to the education requirement, the Missouri State Plan, Supplement 1 to Attachment 3.1-A, page 4-d, requires 1 or more years of professional experience:

- as a registered nurse; or,
- working in the fields of social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy or closely related area; or,
- experience providing direct care to persons who have developmental disabilities.

APPENDIX F: SUMMARY OF ERRORS FOR EACH SAMPLED CLAIM

Table 6: Errors We Identified for Each Sampled TCM Claim

Count	Lack of Documentation of Case Manager Qualifications	Lack of Documentation That TCM Services Were Allowable	Missing Documentation (Case Notes) of TCM Services	Did Not Correctly Account for Recoupment
1				X
2				
3				
4				
5				
6				
7				
8				
9				
10				
11	X			
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32	X			

Count	Lack of Documentation of Case Manager Qualifications	Lack of Documentation That TCM Services Were Allowable	Missing Documentation (Case Notes) of TCM Services	Did Not Correctly Account for Recoupment
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48	X			
49				
50				
51				
52				
53				
54	X			
55				
56	X			
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67	X			
68				
69				

Count	Lack of Documentation of Case Manager Qualifications	Lack of Documentation That TCM Services Were Allowable	Missing Documentation (Case Notes) of TCM Services	Did Not Correctly Account for Recoupment
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				
80	X			
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95		X		
96				
97				
98				
99				
100				
101				
102				
103				
104	X			
105		X		

Count	Lack of Documentation of Case Manager Qualifications	Lack of Documentation That TCM Services Were Allowable	Missing Documentation (Case Notes) of TCM Services	Did Not Correctly Account for Recoupment
106				
107				
108				
109		X		
110				
111				
112				
113	X	X		
114				
115				
116				
117				
118				
119	X			
120	X	X		
121				
122				
123				
124				
125				
126				
127				
128				
129	X			
130				
131				
132				
133				
134				
135				
136				
137				
138				
139				
140				
141				
142				

Count	Lack of Documentation of Case Manager Qualifications	Lack of Documentation That TCM Services Were Allowable	Missing Documentation (Case Notes) of TCM Services	Did Not Correctly Account for Recoupment
143				
144				
145		X		
146				
147				
148				
149				
150	X		X	
151				X
152				
153				
154			X	
155				X
Total	**13**	**6**	**2**	**3**

X – Sample units with an error.

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October 11, 2018

Patrick J. Cogley
Regional Inspector General for Audit Services
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Office of Inspector General
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Kansas City, MO 64106

OFFICIAL CORRESPONDENCE BEING SENT VIA E-MAIL ONLY

RE: Draft Audit Report A-07-17-03219

Dear Mr. Cogley:

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General ("OIG"), draft report entitled, *Missouri Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services*, A-07-17-03219 (August 2018) (hereafter "Draft Audit Report").

The Missouri Department of Social Services ("DSS", "Missouri", or "the State") disagrees with the Draft Audit Report's recommended disallowance of $3,991,093. As explained below, the overwhelming majority of the items questioned by the Draft Audit Report were allowable expenditures consistent with state and federal law and policy. In addition, the disallowance recommendation is based on an extrapolation to the entire audit period of the OIG's conclusion that the federal funds claimed in the sample were unallowable. Extrapolating a disallowance based on isolated errors in complying with documentation rules is inappropriate and inconsistent with federal policies.[1]

* * * *

Case management services "assist [Medicaid recipients] in gaining access to needed medical, social, educational, and other services." SSA § 1905(a)(19). When these services are furnished to one or more specific populations within a State, they are known as "targeted case management" ("TCM"). 42 C.F.R. § 440.169(b).

[1] DSS has attached additional documentation as exhibits to this response.

Allowable TCM includes activities related to assessment, care plan development, referrals, and monitoring. *Id*. at § 440.169(d).

> Assessment: includes a comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. *Id*. This includes taking client history; identifying the needs of the individual and completing documentation; and gathering information from other sources. *Id*.
>
> Care plan development: includes periodic revision of a specific care plan based on information collected through the assessment. *Id*. The plan specifies the goals and actions to address the services needed by the individual; ensures active participation of the individual and works with the individual and others to develop those goals; and identifies a course of action to respond to the assessed needs of the individual. *Id*.
>
> Referral: includes related activities (such as scheduling appointments for the individual) to help the individual obtain needed services, including linking the individual with medical, social, and educational providers or other programs and services that provide needed services to address identified needs and achieve specified goals. *Id*.
>
> Monitoring and follow-up activities: includes activities and contacts necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the individual, and which may be with the individual, family members, service providers, or other entities or individuals. *Id*. Such activities may be conducted as frequently as necessary with at least one annual monitoring. *Id*. This includes determining whether there are changes in the needs or status of the eligible individual and making necessary adjustments in the care plan and service arrangements with providers. *Id*.

Missouri's State Plan includes similar descriptions for allowable case management activities. *See* Exh. 1 (Missouri's State Plan Supplement 1 to Attachment 3.1-A), page 2d.

For this audit, the OIG reviewed the Department of Mental Health's ("DMH") Division of Developmental Disabilities TCM for FY 2014 and 2015. The Draft Audit Report states that the OIG reviewed documentation for 155 randomly selected TCM paid claims from the developmental disability target group.

The OIG found that, of the 155 randomly selected TCM claims, 23 claims had at least one error (some claims had more than one error) related to:

- Case manager qualifications (14 claims)
- Unsupported services (2 claims)
- Accounting errors with recoupment (3 claims)
- Unallowable services (7 claims)

1. The Draft Audit Report Erred in Rejecting 13 of the 14 Claims Based on Case Manager Qualification Issues.

The Draft Audit Report rejects 14 claims on the basis that the State could not provide documentation that the case managers had the qualifications required by the State Plan.

Missouri's TCM State Plan provision requires individuals who provide TCM to have, at a minimum:

1) "One or more years of professional experience: (a) as a registered nurse; (b) in social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, or a closely related area; or (c) in providing direct care to persons who have developmental disabilities; and; and

2) "A bachelor degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in one or a combination of human service field specialties. Additional experience as a registered nurse may substitute on a year-for-year basis for a maximum of two years of required education."

Exh. 1 (Missouri State Plan, Supplement 1 to Attachment 3.1-A), Page 4d.

Neither the State Plan, nor State or federal law, specify which courses meet the human service credit hour requirements. The State is entitled to deference in its interpretation of the State Plan, including the definition of the "human service field" and the courses which qualify as human services, "so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and the applicable federal requirements." *Kansas Health Policy Auth.*, DAB No. 2255 (2009); *Virginia Dep't of Med. Assistance*, DAB No. 1838 (2002); *California Dep't of Health Servs.*, DAB 1474 (1994); *Missouri Dept. of Social Servs.*, DAB No. 1412 (1993); *see also Illinois Dep't of Healthcare & Family Servs.*, DAB No. 2863 (2018); *Virginia Dept. of Medical Assistance Servs.*, DAB No. 1207 (1990). "States have considerable discretion in how to run their programs, and their intent controls in areas where they have options and do not need specific [CMS] approval." *Missouri Dept. of Social Servs.*, DAB No. 1412 (1993).

Thirteen of the 14 claims rejected by the Draft Audit Report were provided by a case manager that DMH concluded met all State Plan requirements. The Draft Audit Report's findings to the contrary were based on incorrect factual findings about the case manager's qualifications and/or a narrow interpretation of coursework in "human service field specialties" that differs from DMH's own reasonable interpretation:

Claim 41: The OIG Final Report Sample Items A-07-17-03219 spreadsheet concluded that the case manager, [redacted] (formerly [redacted][10]), did not meet the qualification requirements because the State did not provide any education or experience documentation.

[10] Office of Inspector General Note—The deleted text in this Appendix has been redacted because it is personally identifiable information.

Ms. [redacted] has a B.A. in Social Work and a minor in Sociology, and completed over 60 human services credit hours. *See* Exh. 2. For example Ms. [redacted] completed: First Aid/CPR (2 credits); Principles of Psychology (3 hours); Intro to Religion (3 hours); Criminology (3 hours); Oral Communication (3 hours); Basic Sociology (3 hours); Intro to Social Work (3 hours); Cultural Anthropology (3 hours); Intro to Human Services (3 hours); The Family (3 hours); Adolescent Psychology (3 hours); Social Problems (3 hours); Social Thought and Theory (3 hours); Intro to Soc. Research (3 hours); Alcohol, Drugs, and Society (3 hours); Management Human Services (3 hours); Urban Sociology (3 hours); Social Deviance (3 hours); Social Work Practice (3 hours); Human Behavior in Social Environments (3 hours); Social Welfare Policies (3 credits); Race & Ethnicity (3 hours); Field Practice (6 hours). *Id.* Her resume also reflects that she has the required experience, as she worked as a service coordinator at DMH for over two years when she applied for the case manager position, and previously worked as a service coordinator at [redacted] for almost two years. *See* Exh. 2.

Claim 54: The Draft Audit Report concluded that the case manager, [redacted], did not meet the case manager qualification requirements.

DMH is providing the transcript and resume for Ms. [redacted], who has a B.A. in Psychology with a minor in Criminal Justice, with the requisite human service credit hours. *See* Exh. 3. Ms. [redacted] also has the required experience, because when she applied for the case manager position she had seven years of experience as a case manager and supervisor. *See id*.

Claims 67, 80, 104, and 119: The OIG Final Report Sample Items A-07-17-03219 concluded that the case manager, [redacted] (formerly [redacted]), did not meet the qualification requirements because DMH failed to provide a transcript to verify her education. The OIG also concluded that Ms. [redacted] did not have the required experience, as her orientation was in July 2013 and OIG's sample month was December 2013, so there was not enough time to gain the required one year of experience. Additionally, Ms. [redacted] resume does not indicate experience working with persons with developmental disabilities.

DMH is providing a copy of the transcript of Ms. [redacted]. Exh. 4. Ms. [redacted] had sufficient credit hours to count towards 24 human service credits: General Psychology (3 credits), Fitness and Wellness (3 credits), Childrens Lifetime Sports Academy (2 credits), Applied Nutrition (2 credits), Human Sexuality (3 credits), Kinesiology (3 credits), Introduction to Sociology (4 credits), Physiology of Exercise (3 credits), Principles of Strength and Conditioning (2 credits), Perspectives in Music (3 credits), Personal and Environmental (3 credits), and Introduction to Aging Studies (3 credits).

Additionally, the experience highlighted on Ms. [redacted] resume satisfies the experience requirements. *See* Exh. 4. Ms. [redacted] worked as: a Community Center Supervisor for the [redacted] from August 2012 until she applied to be a case manager, a substitute teacher in the [redacted] from May 2011 until she applied to be a case manager, a substitute teacher at [redacted] from January 2008 through May 2009, a Health & Wellness Coordinator at [redacted] from January 2008 through August 2008, an Assisted Wellness Director at [redacted] from May 2006 through December 2007, and a substitute teacher at the [redacted] from September

2007 through December 2007. In addition, Ms. [redacted] noted in her employment application that she worked with special needs children. *See* Exh. 5.

Claim 48: The OIG Final Report Sample Items A-07-17-03219 concluded that the case manager, [redacted], did not meet the educational qualifications, because the documentation provided shows she has an uncompleted degree with only 12 human service credits.

DMH has not been able to obtain a complete transcript for Ms. [redacted], who is now retired. *See* Exh. 6. However, Ms. [redacted] was hired on May 1, 2000, and the Office of Administration ("OA") verified her qualifications at that time. DMH previously explained this in a note sent to the OIG. *See* Exh. 7. OA personnel were responsible for verifying DMH employee qualifications. OA would not have verified her qualifications if she had not provided adequate documentation. DMH requested Ms. [redacted] complete transcript from OA on April 13, 2018, but OA responded that it did not have the documentation, but advised to check with the Missouri State Employees' Retirement System ("MOSERs"), which DMH did without success. On April 23, 2018, DMH requested a transcript from Ms. [redacted], again without success.

Claims 113 and 120: The Draft Audit Report concluded that the case manager, [redacted], did not have the educational qualifications.

DMH has located a transcript but it has not yet arrived. Ms. [redacted] eligibility documents were verified through OA. *See* Exh. 8. As previously explained, OA would not have verified her qualifications if she had not provided adequate documentation.

Claim 150: The OIG Final Report Sample Items A-07-17-03219 concluded that the case manager, [redacted], did not meet the education qualification because her transcript shows a B.A. in Photography without the 24 human service field credits.

Ms. [redacted] transcript shows a B.A. in Photography, but her resume and employment application indicate that she also has an Associate Degree in Secondary Education, which would require 24 credit hours in human services. *See* Exh. 9.

Claims 11, 32: The OIG Final Report Sample Items A-07-17-03219 concluded that the case manager, [redacted] (formerly [redacted]), did not meet the qualification requirements because her college transcript did not indicate that she had the required 24 hours of human service credit required by the State Plan.

Ms. [redacted] met the case manager qualification requirements. DMH is providing Ms. [redacted] transcript, which the State has highlighted 26 credit hours that fulfill the human service credit requirement. *See* Exh. 10. The credits are from the following classes: General Psychology (3 credits), General Sociology (3 credits), Artcraft Fundamentals (3 credits), Close Relationship in Family (3 credits), Fundamentals of Music (2 credits), Fundamentals of Abnormal Psychology (3 credits), Principles of Human Development (3 credits), Child Psychology (3 credits), and Social Deviance (3 credits).

Claims 56 and 129: The OIG Final Report Sample Items A-07-17-03219 concluded that the case manager, [redacted], did not meet the requirements because she has a degree in Criminal Justice and her transcript does not document the 24 hours of human service credit hours required by the State Plan Supplement.

Ms. [redacted] met the case manager qualification requirements. DMH is providing Ms. [redacted] transcript, where the State has highlighted 29 hours of course work which count towards the human service credit requirements. Exh. 11. These courses include: Skills for Lifelong Learning I (3 credits), Contemporary Issues in American Business (3 credits), Skills for Lifelong Learning II (3 credits), Critical Thinking (3 credits), Social Science Elective (4 credits), Humanities Elective (4 credits), and Victimology (9 credits).

Claim 54: The Draft Audit Report concluded that the case manager, [redacted] (formerly [redacted]), did not have the required experience, based on her resume.

While Ms. [redacted] has a B.S. in Psychology and Sociology, DMH agrees with the OIG's conclusion that she does not have the required prior experience. DMH will return the unallowable amount associated with this claim, but not the extrapolated amount.

2. The Draft Audit Report Erred in Disallowing Seven Claims Based on a Lack of Documentation of Allowable TCM.

Federal law requires providers "to maintain case records that document for all individuals receiving case management" "[t]he nature, content, units of the case management services received and whether goals specified in the care plan have been achieved", among other things. 42 C.F.R. § 441.18(a)(7)(iv). As noted above, case management services "assist [Medicaid recipients] in gaining access to needed medical, social, educational, and other services." SSA § 1905(a)(19). The State Plan requires the completion of case documentation, which includes progress notes. Exh. 1 (Missouri State Plan, Supplement 1 to Attachment 3.1-A), page 3d.

The Draft Audit Report rejects seven claims on the basis that the case notes lacked sufficient detail to support that the claimed services were allowable in accordance with federal requirements, the State Plan, or both. DMH disagrees with the Draft Audit Report's conclusion regarding these claims.

Claim 2: The OIG Final Report Sample Items A-07-17-03219 spreadsheet concluded that the services were not allowable because the case note does not address support for the recipient or how the activities apply to the plan of care.

The service is for an allowable TCM service. The case note indicates that the case manager arranged for medical equipment for the individual receiving case management, which is general case management planning support. *See* Exh. 12. In addition, this activity relates to the plan of care, which discusses the individual's use of medical equipment such as a gastrostomy tube for feeding and ankle-foot orthoses for walking. *See* Exh. 13.

Claim 95: The OIG Final Report Sample Items A-07-17-03219 spreadsheet concluded that nine of the billed units for this sample item were erroneous, as they mention a different beneficiary's name.

The payment for the service was valid because the claim was an allowable TCM activity; the service was simply included on the wrong beneficiary's case log. *See* Exh. 14. Instead of being correctly included on [redacted] case log, it was incorrectly included on [redacted] case log. DMH has verified that the claim was not already billed for that date of service, that [redacted] was Medicaid eligible, and that [redacted] was on the service coordinator's caseload. DMH's payment for this claim was appropriate, as the service provided was an allowable TCM activity.[2]

Claim 105: The OIG Final Report Sample Items A-07-17-03219 spreadsheet concluded that the time for the service was billed twice for the same tasks, as the service provided on November 13, 2013 is a word-for-word repeat of the case note on November 8, 2013.

DMH did not bill twice for the same task. Instead, the documentation simply shows that the task was started on one day and completed on a later day. The case notes describe the service coordinator filling out the individual's person centered support plan. *See* Exh. 15. This included adding information regarding supports needed, things about the individual, medical information, rights and responsibilities, the individual's dreams, in case of emergency, communication, and how to accomplish the individual's stated dreams and objectives. The service coordinator spent 135 minutes on this task on November 8, 2013, and spent 145 minutes completing this task on November 13, 2013. Billing for this service on two different days is allowable, as it took time on two different days to complete the task.

Claim 109: The OIG Final Report Sample Items A-07-17-03219 spreadsheet concluded that the service provided on August 25, 2014, was an unallowable TCM service.

The case note reads: "client has money in her personal account for spending, client wants a new bedroom set, cm assisted client with [redacted] for selecting the correct bed size and delivery charge for the amount of funds clients has to spend on a bedroom set and full size mattress … 30 minutes of travel included". Exh. 16.

The service provided on August 25, 2014 is an allowable TCM service because the case manager assisted the individual in accessing her personal funds. DMH was the payee for this individual during the audit period, and was handling rent payments and the individual's personal spending funds. The Technical Assistance Manual's definition of "Linking Resources" includes "[c]ompleting forms or entering data into a computer, as needed to set up a service and/or have payment for services authorized." Exh. 17 (Technical Assistance Manual), at 22. As such, the service is allowable.

The case notes also indicate that "[t]his assistance included 30 minutes of travel." The claim is allowable because the case notes do not indicate that the individual was in the car during the transportation, and case managers are allowed transportation from the TCM service. The Technical Assistance Manual states that "linking resources" "[i]ncludes time spent

[2] We use initials to protect the privacy of the individuals involved.

traveling to/from meetings as long as the log/case note indicates how much time was spent in travel." *Id.* at 22 (emphasis added). The State Plan also notes that "[t]ime spent in case management activities may consist of in-person or other contacts with the individual and all others involved or concerned with his care, compiling and completing necessary planning and other documentation, and travel to and from contacts". Exh. 1 (Missouri State Plan, Supplement 1 to Attachment 3.1-A), Page 3dd (emphasis added). The August 25, 2014 log notes indicate that travel was 30 minutes. Claim 109 is therefore allowable.

Claims 113 and 120: The Draft Audit Report concluded that three service dates had unallowable services.

OIG did not specify which service dates had unallowable services. Upon review, all of the services included in the log notes for Claims 113 and 120 are for allowable services. *See* Exhs. 18 and 19. DMH requests that the OIG describe in detail why it believes the six total service dates are not allowable services.

Claim 145: The Draft Audit Report concluded that the note on December 6, 2013 was erroneously documented in the wrong case file. The note discusses [redacted], uses the pronoun "her", and refers to the beneficiary's mother as [redacted]. However, the beneficiary in the sample is a male named [redacted], and his mother is [redacted].

The payment for the service was valid because the claim was an allowable TCM activity; the service was simply included on the wrong beneficiary's case log. *See* Exh. 20. Instead of being correctly included on [redacted] case log, it was incorrectly included on [redacted] case log. DMH has verified that the claim was not already billed for that date of service, that [redacted] was Medicaid eligible, and that [redacted] was on the service coordinator's caseload. DMH's payment for this claim was appropriate, as the service provided was an allowable TCM activity.

3. Claims 150 and 154 Reflect Allowable TCM.

The Draft Audit Report rejects two claims on the basis that the State did not provide the underlying case notes related to the TCM service.

Medicaid providers are required "(A) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request." SSA §1902(a)(27).

Claim 154: The OIG Final Report Sample Items A-07-17-03219 spreadsheet recommended a disallowance for 24 units the case manager billed on December 4, 2013, because the case manager provided transport to a client in a case manager vehicle, which is a "direct service" and thus not a billable TCM activity.

Claim 154 reads: "linking resources with facilitation of isl tour with consumer, [redacted] staff and [redacted] staff for potential placement in Jefferson city with location too dangerous and two other sites, home and apartment, toured with sc concerned on ability of provider to offer

sufficient and safe care of the consumer; travel to/from office to Jefferson city, 120 minutes". Exh. 21.

The claim is allowable because service coordinators are allowed transportation from the TCM service. Missouri's Technical Assistance Manual notes that "linking resources" is a "legitimate TCM activity", Exh. 17 at 31, which "involves matching the unique support needs of individuals and families … with resources in the community." *Id*. at 21. This "*[i]ncludes time spent traveling to/from meetings* as long as the log/case note indicates how much time was spent in travel." *Id*. at 22 (emphasis added). The State Plan also notes that "[t]ime spent in case management activities may consist of in-person or other contacts with the individual and all others involved or concerned with his care, compiling and completing necessary planning and other documentation, and *travel to and from contacts*". Exh. 1 (Missouri State Plan, Supplement 1 to Attachment 3.1-A), Page 3dd (emphasis added). The case notes do <u>not</u> indicate that the individual was in the car during the transportation, and thus this was not a direct transportation service.

The Draft Audit Report characterizes Claim 154 in the "unsupported services/missing documentation" category of claims it has issue with. Yet in the OIG Final Report Sample Items A-07-17-03219 spreadsheet, the OIG describes part of the reason for the error in Claim 154 as the fact that the case manager provided transportation to the client, among other reasons. These two explanations for the errors are inconsistent, as the fact that the case manager allegedly provided transportation to the client is not an issue related to missing documentation. The OIG also asserts in Claim 154 that there are four case note units missing from the sample item. DMH requests that the OIG explain why it believes four missing case notes are missing.

<u>Claim 150</u>: The Draft Audit Report notes that "[a]dditional information received reports Primary DT code was billed as a '1' instead of a '2' - Thus, two erroneously billed units remain." DMH requests clarification regarding what the OIG means by this statement.

4. The State Correctly Accounted for TCM Claims it Recouped on the CMS-64 Reports.

The Draft Audit Report rejects three claims on the basis that the State did not correctly account on its CMS-64 reports for TCM paid claims it recouped from a TCM provider. The Draft Audit Report explains that DMH paid one TCM provider for three claims at an incorrect rate and acknowledges that DMH properly recouped the original payment from the TCM provider, and then paid the provider at the correct rate. However, the Draft Audit Report alleges that the State did not correctly account for the recoupment in the MMIS claims data, which resulted in the State not crediting the federal government the FFP for the recouped funds.

The State disagrees with this finding. Attached is a spreadsheet summarizing data pulled from the State's MMIS claims data, which shows that the State properly accounted for the recoupment in the MMIS data. *See* Exh. 22. The State has no reason to believe this was not correctly translated into the CMS-64 data.

If the OIG continues to believe that the State failed to account for these recoupments in the CMS-64 data, the State respectfully requests that the OIG provide the State (in the final Audit Report) with documentation to support that conclusion.

5. The OIG Sampled From Only 98% of TCM Claims.

For this Draft Audit Report, the OIG reviewed a stratified random sample totaling 155 TCM paid claims from the developmental disability target group. According to the Draft Audit Report, this group represented over 98 percent of all TCM claims in Missouri in FYs 2014 and 2015.

The OIG should have sampled claims from 100 percent of all TCM claims in Missouri during the relevant time period, not 98 percent. DMH requests that the OIG explain its decision to sample from only 98 percent of TCM claims, as opposed to 100 percent.

6. Extrapolation is Inappropriate Given the High Rate of Compliance.

Not only did the OIG advance inappropriate disallowance recommendations for sampled claims, but it then extrapolated its findings onto the universe of DMH's claims during the audit period. From the OIG's random stratified sample of 155 claims, the OIG concluded there was $11,796 in unallowable federal share in that sample. It then extrapolated these findings onto a universe of 354,626 claims, and estimated, using a 90 percent confidence interval, that the federal share of unallowable services fell somewhere between $3,991,093 and $10,862,169, an almost $7 million range.

Just because Missouri does not have all of the requisite documentation does not mean the entirety of each claim should be invalid and extrapolated to all other claims. Most of the noncompliance cited in the Draft Audit Report was not sufficiently serious or material to justify recoupment. As explained above, the majority of the claims that the OIG identified were based on issues identified with DMH's documentation. Federal Medicaid law contemplates the loss of federal funding only for violations of a certain level of seriousness or materiality. For example, CMS will withhold federal funding for noncompliance in the administration of the State Plan only if "there is failure to comply *substantially* with any of [the provisions of Section 1902 of the Social Security Act]." 42 C.F.R. § 430.35(a)(2) (emphasis added). Other remedies, such as corrective action measures, may be imposed for less significant issues of noncompliance, though in some circumstances even corrective action will be required only for serious violations, *see id*. § 430.32 (Medicaid program reviews will only result in state corrective action "[i]f Federal or State reviews reveal *serious* problems with respect to compliance with any Federal requirement" (emphasis added)).

Authorizing different remedies for different levels of seriousness and materiality is supported by basic principles of contract law. As CMS states on its website, "[a] State Plan is a contract between a state and the federal government describing how that state administers its Medicaid program." It is black-letter contract law that if a breach of contract did not cause any compensable injury, the non-breaching party is entitled to only nominal damages. *See* Joseph M. Perillo, Corbin on Contracts § 55.10 (2005). In the Medicaid context, the federal government provides FFP in exchange for the state safely providing valid medical assistance to an eligible beneficiary. If the claim does not violate the rules in a manner that suggests the services were invalid or provided to an ineligible beneficiary, or delivered in an unsafe manner, the noncompliance will not have caused any harm to the federal government. The federal

government will have received what it paid for, and a refund of federal dollars will be inappropriate, just as actual damages would be inappropriate for a non-breaching party left unharmed by a breach of contract.

In short, a federal refund is only warranted when the auditor finds evidence of serious, material noncompliance with federal rules suggesting the services rendered were invalid. In this audit, the OIG seized on any missing piece or non-material errors, however isolated, to conclude that the claim for Medicaid reimbursement was unallowable.

Further, extrapolation is unwarranted in light of the high rate of compliance demonstrated by this Draft Audit Report. The small number of actual documentation violations in each category demonstrates that there is no widespread or systemic noncompliance.

Incorporating DMH's responses above to each claim, the Draft Audit Report should have rejected only two of the 155 sampled claims, which is an error rate of 1.3 percent. (DMH has excluded the 2 claims regarding the provision of documentation because it has requested clarification from the OIG on the issues).

This error rate is lower than error tolerance levels established in various quality control programs in Medicaid and other federally funded programs. *See, e.g.*, 42 C.F.R. § 431.865 (establishing a 3 percent tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program); *id*. § 483.45(f) (requiring pharmacy facilities to be free of medication error rates of 5 percent or greater, and be free of significant medication errors); 45 C.F.R. § 1356.71(c)(4)-(6) (explaining that a Title IV-E agency is in substantial compliance if the error rate is below 10% or 15%, depending on whether it is an initial or a subsequent primary review); *id*. § 205.42 (1980) (establishing a 4% tolerance limit for payment errors in the Aid to Families with Dependent Children program).

The standard federal policy, when overall performance is within the established tolerance limits, is to seek recovery only for noncompliance actually identified, and not to extrapolate the results of a review to the caseload as a whole. The OIG itself rejects extrapolation when 5% or less of a sample are deficient. *Puerto Rico Dep't of Health*, DAB No. 2385, 12-13 (2011). If the OIG recommends a disallowance for the technical noncompliance purportedly identified in this Draft Audit Report, it should at least forego extrapolation where the rate of noncompliance is so low.

The OIG should not be able to sample from one subset of claims, and extrapolate those findings to a different pool of claims.

7. The State Will Follow Federal Requirements and State Agency Guidelines.

In addition to refunding $3,991,093 to the federal government for allegedly unallowable TCM claims, the OIG's Draft Audit Report recommends that the State strengthen its policies and procedures to ensure that TCM providers maintain required documentation, it does not pay TCM providers or claim federal reimbursement for unallowable TCM, and it correctly reports recoupment of TCM claims from TCM providers on its CMS-64 reports.

The State will continue to work to comply with federal requirements in providing and claiming TCM.

As outlined above, a federal refund is not appropriate for the overwhelming majority of claims challenged by the OIG. Most of the alleged deficiencies are not violations of federal law and do not amount to material noncompliance with state or federal law. Additionally, extrapolation is inappropriate for this audit.

Thank you for the opportunity to comment on this draft report. Please feel free to contact Helen Jaco at (573) 751-7533 if you have additional questions.

Sincerely,

/s/

Steve Corsi, Psy. D

SC:bb

Attachment

cc: James Scott