DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RICHMOND, VIRGINIA

RESPITE CARE REVIEW

AS OF OCTOBER 31, 1999

AUDITOR OF PUBLIC ACCOUNTS

COMMONWEALTH OF VIRGINIA

Commonwealth of Virginia

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Introduction

In May 1999, the Department of Medical Assistance Services (DMAS) notified this Office that they had received allegations from one of their providers concerning an employee's falsification of Medicaid billings. Based on the nature of the allegations, we recommended that DMAS management immediately contact the State Police, which they did.

Our Office, the State Police, and DMAS's Internal Auditors and program personnel met and began a preliminary investigation of the allegations. On June 4, 1999, based on preliminary findings, we communicated to you that DMAS had notified us of the possibility of improper Medicaid payments and that the potential loss could exceed $100,000.

Since then, we continued to meet with representatives of DMAS, the State Police, and the Office of the Attorney General to discuss the circumstances. The State Police asked us to assist with its investigation, and this report summarizes the work we performed and our findings.

Summary of Audit Work

In June and July 1999, we reviewed DMAS's internal controls and its Medicaid Management Information System (MMIS). During this period, we also reviewed 100 percent of the documents of a respite care provider *(Respite Care Provider #1)* that was cooperating in the investigation, identifying over $118,000 in apparent fraudulent respite care claims. In October 1999, we made onsite visits to three additional respite care providers, examining recipient records and supporting documentation to determine if the providers were submitting valid respite care claims. These providers had submitted valid claims.

Summary Of Findings

Review of Respite Care Provider #1

- $118,390 of $129,362 in respite care claims submitted from 1995 through 1998 appeared fraudulent.

Review of Three Additional Respite Care Providers

- No indications of fraud, but found numerous program compliance violations.

Review of DMAS's Medicaid Management Information System (MMIS)

- No system controls existed to provide an audit trail for the authorization of respite care.
- No system controls existed to provide an audit trail for changes to billing or patient information entered by a DMAS analyst.
- No system controls existed to ensure that a provider does not bill for respite care services in excess of the 720-hour limit each year.
- There are no standard calculations to convert the daily respite care rate into hours for purposes of tracking the 720-hour limit.

Review of DMAS's Internal Control Procedures

- Patients may receive care before a DMAS analyst has reviewed the provider's *Plan of Care* for consistency with the Screening Team's recommendation.
- DMAS requires no written documentation from the provider or caregiver to activate respite care.
- DMAS provides limited oversight of its analysts in assigning both providers and recipient cases.
- DMAS failed to perform utilization reviews of provider agencies for more than three years.

Details on the respite care process, audit work performed, and our audit findings are included on the following pages.

Respite Care Process

General

Medicaid covers both personal care and respite care services, which are community-based care programs. Personal care, which cost DMAS in excess of $77 million during 1999, is the routine care patients receive on a daily basis (e.g., bathing, meal preparation). Respite care allows nonprofessional (e.g., family) caregivers a "break" for personal illness or vacation. Respite care services has a limit of 30 days or 720 hours per year and cost DMAS in excess of $776,000 during fiscal year 1999. Many recipients who receive personal care are eligible for respite care.

Authorization Process

For a Medicaid recipient to receive home health services, an individual must be functionally dependent, require medical and nursing supervision of care, and must be at risk to require nursing facility care. A Pre-Admission Screening Team, comprised of local health department officials and a Department of Social Services representative, determines the type and level of service and lists the provider choices and payment responsibility. Once selected, the provider agency receives information about the recipient and sends a nurse to assess the recipient's condition and develop a Plan of Care.

The Plan of Care specifies the daily tasks and the hours associated with each task. A DMAS analyst examines each recipient's supporting documentation to ensure that the service level recommended by the provider is consistent with the Screening Team's evaluation. When the review is completed, the analyst sends a Community-Based Care Authorization Form to the provider agency.

On behalf of their recipients, providers request respite care services from DMAS via telephone or letter. DMAS analysts enter request information into MMIS, which then sends an acknowledgement letter to the provider. The DMAS analyst then verifies respite care eligibility and enters an authorization code into MMIS, which generates a letter authorizing the provider to bill DMAS for respite services. This letter designates the type of service, the effective date of service, and the approved number of hours.

Billing Process

Providers request payment for services using the Medicaid HCFA 1500 Form, which they sent directly to DMAS's fiscal agent, First Health Services. Providers can send claims by mail, electronically, or directly on-line. Once First Health Services enters the billing data into MMIS, the system verifies the following:

- Recipient eligibility
- Provider authorization
- Provider service code
- No claim duplication
- Eligibility period

Once the claim passes all edits, DMAS pays the claim. DMAS will pay all valid claims received within one year of the provided service date.

Audit Work

Respite Care Provider #1

We reviewed 100 percent of all respite care claims from this provider for all patients from 1995 through 1998 and found that $118,390 of $129,362 claims, or 92 percent, appeared fraudulent. In these instances, the provider did not have Aide Logs to support that recipients actually received respite care services as required by DMAS. Only 7 of the 26 recipients legitimately received respite care services. We also found that it appears that a DMAS analyst completed approximately 52 percent of the billings.

It appears that the provider, in collusion with a DMAS analyst, submitted improper respite care billings using the following methods:

1. The provider supplied the analyst with signed billing forms that did not include any information other than the signature of the provider. The analyst completed these forms for recipients eligible for respite care. This type of improper claims comprised the majority of the questioned claims submitted.

2. In the remaining claims, the DMAS analyst supplied the provider with information necessary to complete the improper claims. Because DMAS allows provider agencies to submit billing claims for up to one year after the date of service, the analyst could easily identify those individuals who had not used respite care within the eligibility year and submit those improper claims.

The provider or analyst then forwarded the billing forms directly to First Health for payment to the provider. After receiving payment from First Health for these improper claims, the provider split the proceeds with the analyst.

Review of Other Provider Records

Based on information received from the State Police, we reviewed respite care files for three other providers that dealt with the same DMAS analyst. We reviewed the records of 84 recipients, including all respite care claims submitted for 1998 and 1999 and a sample of claim payments from 1995 through 1997. During our review, we identified numerous compliance violations, but found no evidence of consistent errors that would indicate any improper claims. DMAS plans to address these issues separately with these providers.

Review of DMAS Operations and MMIS

During our review of DMAS's operations and MMIS, we noted the following problems:

1. MMIS – Provides no individual accountability for authorization through system controls because analysts know each other's authorization code.

Each analyst should have a unique logon identification and password, which only that analyst can use. If an analyst attempts to use another analyst's authorization code, the system should generate an "Invalid Authorization Report" to identify unauthorized usage.

2. **MMIS - Analysts can change and delete line and entire entries on the Recipient Eligibility File Screen without any supervisory review or approval and MMIS does not maintain records of changes. For example, an analyst can change the effective dates of service, as well as the provider identification for a recipient without changing or deleting the original analyst's identification number or other original information.**

   The system should generate a "Change Report" to identify both the changes to a recipient's record and who entered the changes. Further, management should consider changing the system to require supervisory approval for certain changes.

3. **MMIS - The system does not have an edit to determine if providers bill more than 720 hours for respite care in a year. MMIS prevents a provider from billing for more than 30 days within a month for a recipient.**

   DMAS should change MMIS so that it can track the 720-hour limit for each recipient.

4. **MMIS - There are no standard calculations to convert the daily respite care rate into respite care hours for purposes of tracking the 720-hour limit. When respite care is provided for less than 13 hours per day, providers bill DMAS for each hour of service at an hourly rate. When respite care is provided for 13 – 24 hours per day, providers bill DMAS at a standard daily rate, regardless of the number of hours worked. The system is unable to convert that standard daily rate into hours for purposes of tracking the 720-hour limit per year per recipient.**

   DMAS should change MMIS to allow DMAS analysts to enter actual hours into the system, even if the daily respite care rate is used for reimbursement. This will enable DMAS to properly track all respite care hours for each recipient to ensure that the 720-hour limit is not exceeded.

5. **Operational - Providers can receive payment for respite care before a DMAS analyst reviews the provider's Plan of Care for consistency with the Screening Team's recommendation.**

   DMAS analysts should not approve respite care for a recipient until he/she has reviewed the Plan of Care for consistency with the Screening Team's recommendation.

6. **Operational – Neither the provider or recipient must document their request for respite care.**

   DMAS should require both the caregiver and provider to document any requests for respite care services in writing.

7. **Operational - DMAS analysts receive limited management oversight and do not consistently follow internal operating procedures. For example, DMAS analysts should randomly select billing information for processing. However, our review showed that the same analyst often processed all information from a provider.**

   Management should review the level of supervision and training that DMAS analysts receive. Management should determine if analysts understand DMAS's polices and procedures, especially the need to not allow one analyst to work solely with one provider.

8. Operational - DMAS has not performed utilization reviews of provider agencies for more than three years.

The DMAS Waiver Services Unit conducts reviews of providers to ensure that proper documentation exists to support claims. Due to staffing changes, DMAS has not performed any utilization reviews since 1996. DMAS should try to perform Provider Utilization Reviews at least once a year to ensure proper billing and adequate levels of service.

Conclusion

Although the respite care situation involved collusion with a DMAS analyst, the lack of adequate DMAS internal and system controls provides many opportunities for providers to take advantage of both respite care and personal care payment processes. DMAS needs to improve its internal control policies and procedures over its home health services, including its monitoring of the service providers. Further, the lack of adequate system controls requires that DMAS completely reevaluate and update its Medicaid Management Information System. Without significant changes in these major areas, DMAS will continue to be highly susceptible to Medicaid fraud.

We completed our investigation in October 1999, but delayed issuance of this report at the request of the Attorney General's Office pending further investigation. In July 2000, the Attorney General's Office stated that it is continuing its investigation, but indicated that we could proceed to issue our report.

DMAS has been developing a new information system for the past eight years. System controls cited above that are absent from the current MMIS system will be included in the new MMIS system scheduled for completion by June 2001.

Sincerely,

Walter J. Kucharski
Auditor of Public Accounts

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