

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MISSOURI CLAIMED  
UNALLOWABLE MEDICAID PAYMENTS  
FOR INDIVIDUALIZED  
SUPPORTED LIVING  
HABILITATION SERVICES**

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**March 2016  
A-07-14-03202**

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## EXECUTIVE SUMMARY

*Missouri claimed \$1.5 million of unallowable Medicaid payments for individualized supported living habilitation services under its home and community-based services developmental disabilities waiver program during State fiscal years 2011 through 2013.*

### WHY WE DID THIS REVIEW

This audit is our second review of Missouri's developmental disabilities waiver program, which is one of several Medicaid home and community-based services (HCBS) waiver programs. Our first review of Missouri's developmental disabilities waiver program determined that the Missouri Department of Social Services, Missouri HealthNet Division (State agency), claimed unallowable and unsupported Medicaid payments for some group home habilitation services. This report will address the results of our review of individualized supported living (ISL) habilitation services provided under Missouri's developmental disabilities waiver program.

The objective of this review was to determine whether the State agency's Medicaid payment rates for ISL habilitation services provided and paid for during State fiscal years (SFYs) 2011 through 2013 were in accordance with Federal requirements.

### BACKGROUND

Section 1915(c) of the Social Security Act (the Act) authorizes Medicaid HCBS waiver programs. A State's HCBS waiver, which must be approved by the Centers for Medicare & Medicaid Services (CMS), allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible individuals in the community rather than in an institutional setting.

The State agency administers the provision and payment of Medicaid services in Missouri. In Missouri, the developmental disabilities waiver (referred to in Missouri as the developmental disabilities comprehensive waiver) program is 1 of 10 waiver programs covered under the HCBS waiver and is operated by the Missouri Department of Mental Health (DMH). The developmental disabilities waiver program includes ISL habilitation services, which provide assistance and necessary support to achieve personal outcomes that enhance individuals' ability to live in and participate in their communities. These services are provided to individuals in residences (house or apartment); each of these residences must be owned or leased by at least one of the individuals residing in the residence and/or by someone, such as a family member or legal guardian, who has been designated by the owner or lessee.

The State agency pays providers of ISL habilitation services (ISL providers) at a per-diem payment rate that is specific to each individual who is receiving these services. Missouri's developmental disabilities waiver states that as the first step in developing that payment rate, an approved ISL provider proposes a monthly budget based on the individual's needs (ISL budget) as described in his or her DMH individual service plan and submits it to DMH for approval. DMH reviews the proposed ISL budget, makes adjustments if needed, and approves the final ISL

budget, which the State agency then uses to determine the per-diem payment rate for the individual.

Missouri's developmental disabilities waiver lists the types of costs that can be included in an individual's ISL budget for use in determining the payment rate for ISL habilitation services. The developmental disabilities waiver also states that payment rates for ISL habilitation services do not include room-and-board costs. Rather, DMH should pay room-and-board costs directly to ISL providers using State-only funds.

## **WHAT WE FOUND**

The State agency's Medicaid payment rates for ISL habilitation services provided and paid for during SFYs 2011 through 2013 were not always in accordance with Federal requirements. Specifically, the State agency included costs that were not approved by DMH in some of its payment rates for ISL habilitation services. In addition, the State agency included unallowable costs in some of its payment rates for these services. Because these unapproved and unallowable costs were prohibited under Federal requirements, the associated payments were unallowable.

Because the State agency included unapproved and unallowable costs in some of its payment rates for ISL habilitation services, and on the basis of our sample results, we estimate that it claimed unallowable Medicaid payments of \$2,185,638 (\$1,455,378 Federal share) during SFYs 2011 through 2013.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$1,455,378 to the Federal Government and
- follow Federal requirements when determining the payment rates for ISL habilitation services by including only costs that DMH has approved and by excluding unallowable costs.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency disagreed with our first recommendation and stated that it would continue to work to comply with Federal requirements and State agency guidance with respect to our second recommendation.

Regarding our first recommendation, the State agency said that the overwhelming majority of the costs (the State agency referred to these as budget line items) that we questioned were allowable expenditures authorized under Missouri's developmental disabilities waiver. With respect to the administrative costs that we had categorized as unallowable, the State agency said that it was inappropriate for the Federal Government to disallow Federal funds based on noncompliance with State policies. The State agency added that we did not provide sufficient information to support our position that some costs were not approved by DMH. Finally, the State agency said

that we based the amount of disallowed costs in our draft report's first recommendation on an extrapolation of our conclusion that approximately 2 percent of the reviewed costs were unallowable or unapproved. According to the State agency, "Extrapolating a disallowance based on such a small error rate is inconsistent with [F]ederal policies." The State agency supported this assertion by citing Federal regulations pertaining to quality control programs in Medicaid and in Aid to Families with Dependent Children.

After reviewing the State agency's comments, we identified within them those pieces of information and explanation that had not previously been given to us, and we revised some of our findings and adjusted the dollar amount in our first recommendation accordingly. Otherwise, though, we maintain that our findings and recommendations, as they appear in this final report, are valid. We based our extrapolation (that is, our projection) on the dollar value of the errors in our sample to appropriately estimate the overall value of the sampling frame. The State agency's comments indicated a misunderstanding of Federal policy regarding extrapolation and relied on regulations that are not applicable to the Medicaid HCBS waiver program or to the Office of Inspector General and, in the case of one of those quality control programs, relied on a regulation that is no longer in effect.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

This audit is our second review of Missouri's developmental disabilities waiver program, which is one of several Medicaid home and community-based services (HCBS) waiver programs. Our first review of Missouri's developmental disabilities waiver program determined that the Missouri Department of Social Services, Missouri HealthNet Division (State agency), claimed unallowable and unsupported Medicaid payments for some group home habilitation services. This report will address the results of our review of individualized supported living (ISL) habilitation services provided under Missouri's developmental disabilities waiver program.

### OBJECTIVE

Our objective was to determine whether the State agency's Medicaid payment rates for ISL habilitation services provided and paid for during State fiscal years (SFYs) 2011 through 2013 were in accordance with Federal requirements.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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 63.29 percent to 74.43 percent.<sup>1</sup>

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<sup>1</sup> Under the provisions of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Feb. 17, 2009) as amended by P.L. No. 111-226 (Aug. 10, 2010), States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011. Our calculations took the increased FMAPs into account for the portion of our audit period (four quarters) affected by the State's increased FMAPs. (See Appendix A.)

## **Home and Community-Based Waivers**

Section 1915(c) of the Act authorizes Medicaid HCBS waiver programs. A State's HCBS waiver, which must be approved by CMS, allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible individuals in the community rather than in an institutional setting.

### **Missouri Medicaid Program**

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

### **Missouri Developmental Disabilities Waiver Program**

In Missouri, the developmental disabilities waiver program is 1 of 10 waiver programs<sup>2</sup> covered under the HCBS waiver and is operated by DMH. The developmental disabilities waiver program includes ISL habilitation services, which provide assistance and necessary support to achieve personal outcomes that enhance individuals' ability to live in and participate in their communities. These services are provided to individuals in residences (house or apartment); each of these residences must be owned or leased by at least one of the individuals residing in the residence and/or by someone, such as a family member or legal guardian, who has been designated by the owner or lessee.

### **Methodology for Setting Payment Rates for Individualized Supported Living Habilitation Services**

The State agency pays providers of ISL habilitation services (ISL providers) at a per-diem payment rate that is specific to each individual who is receiving these services. Missouri's CMS-approved developmental disabilities waiver<sup>3</sup> states that as the first step in developing that payment rate, an approved ISL provider proposes a monthly budget based on the individual's needs (ISL budget) as described in his or her DMH individual service plan<sup>4</sup> and submits it to DMH for approval. DMH reviews the proposed ISL budget, makes adjustments if needed, and approves the final ISL budget, which the State agency then uses to determine the per-diem payment rate for the individual.

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<sup>2</sup> There are a total of 10 waivers under Missouri's HCBS waiver program. The Missouri Department of Mental Health (DMH) operates five of the HCBS waiver programs, including the developmental disabilities waiver program; the other five are operated by the Missouri Department of Health and Senior Services (DHSS). The State agency, DMH, and DHSS, are separate entities of the Missouri State Government.

<sup>3</sup> Application for a §1915(c) Home and Community-Based Services Waiver, Developmental Disabilities Comprehensive Waiver (July 1, 2011).

<sup>4</sup> An individual service plan is a document prepared by a case manager. Individualized in its scope, it identifies the client's goals, strengths, and needs, as well as all DMH services and programs that address those needs. Services identified in the individual service plan must, to the greatest extent possible, be consistent with the individual's preferences and be provided in the least restrictive setting.

Missouri's developmental disabilities waiver lists the types of costs that can be included in an individual's ISL budget for use in determining the payment rate for ISL habilitation services. The developmental disabilities waiver also states that payment rates for ISL habilitation services do not include room-and-board costs.<sup>5</sup> Rather, DMH should pay room-and-board costs directly to ISL providers using State-only funds.

## **HOW WE CONDUCTED THIS REVIEW**

We reviewed the State agency's supporting documentation (that is, the ISL budgets) for a stratified random sample of 100 individuals and the associated payment rates for ISL habilitation services provided and paid for during SFYs 2011 through 2013.<sup>6</sup> We identified unapproved and unallowed costs that were included in the payment rates. We then recalculated the payment rates excluding the unapproved and unallowable costs and applied the rates to the actual MMIS claims for ISL habilitation services provided and paid for during SFYs 2011 through 2013. On the basis of the recalculated payment rates, we estimated the unallowable Medicaid reimbursement paid for claims in the sampling frame of 4,636 individuals.

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 A contains details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## **FINDINGS**

The State agency's Medicaid payment rates for ISL habilitation services provided and paid for during SFYs 2011 through 2013 were not always in accordance with Federal requirements. Specifically, the State agency included costs that were not approved by DMH in some of its payment rates for ISL habilitation services. In addition, the State agency included unallowable costs in some of its payment rates for these services. Because these unapproved and unallowable costs were prohibited under Federal requirements, the payments were unallowable.

Because the State agency included unapproved and unallowable costs in some of its payment rates for ISL habilitation services, and on the basis of our sample results, we estimate that it

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<sup>5</sup> Costs of room and board are allowable if they are part of respite care services in State-approved facilities that are not private residences or under waivers that allow personal caregivers to provide approved, designated services (42 CFR § 441.310(a)(2)). These types of allowable room-and-board costs are not a factor in the findings conveyed in this audit report.

<sup>6</sup> ISL payment rates can change because of cost-of-living adjustments, service needs, and changes in providers. For this reason, our sample of 100 individuals had a total of 3,170 payment rates during our audit period.

claimed unallowable Medicaid payments of \$2,185,638 (\$1,455,378 Federal share) during SFYs 2011 through 2013.<sup>7</sup>

## **FEDERAL REGULATIONS AND MISSOURI'S DEVELOPMENTAL DISABILITIES WAIVER REQUIREMENTS**

Room-and-board<sup>8</sup> costs are generally not allowable under an HCBS waiver (42 CFR § 441.310(a)(2)) (except as noted in footnote 5). In addition, a State's HCBS waiver services must meet certain requirements for the State to receive Medicaid reimbursement (42 CFR §§ 440.2(b) and 440.180).

Missouri's CMS-approved developmental disabilities waiver states that after an ISL provider develops an ISL budget based on the individual's needs, DMH reviews the proposed ISL budget, makes adjustments if needed, and approves the ISL budget, which then becomes the payment rate that is developed for that individual.

Missouri's developmental disabilities waiver also lists the types of costs that can be included in the payment rate for ISL habilitation services: direct support staff, professional management, travel, backup and safety-net supports, registered nurse oversight, and administrative costs. In addition, Missouri's developmental disabilities waiver states that payment rates for ISL habilitation services do not include room-and-board costs. Rather, DMH should pay room-and-board costs directly to ISL providers using State-only funds. Room-and-board costs listed as unallowable in the developmental disabilities waiver include costs associated with rent, utilities, food and clothing, and housekeeping.

Furthermore, Missouri's developmental disabilities waiver states that ISL habilitation services payment rates are based on a daily rate and are negotiated between the provider and DMH in accordance with DMH's procedures and policies for payment rate setting. (Application for a §1915(c) Home and Community-Based Services Waiver, Developmental Disabilities Comprehensive Waiver, Appendix C, "Participant Services," Appendix I-2, "Rates, Billing and Claims," and Appendix I-5, "Exclusion of Medicaid Payment for Room and Board" (July 1, 2011)).

Details on the requirements of these Federal regulations and Missouri's developmental disabilities waiver with respect to Medicaid payments for ISL habilitation services appear in Appendix D.

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<sup>7</sup> We have conservatively identified unallowable Medicaid payments at the *lower* limit of a two-sided, 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual unallowable Medicaid payments total at least 95 percent of the time.

<sup>8</sup> CMS's *State Medicaid Manual*, section 4442.3.B.12, defines "room" as hotel or shelter-type expenses, including all property-related costs (e.g., rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services) and defines "board" as three meals a day or any other full nutritional regimen.

## **THE STATE AGENCY'S MEDICAID PAYMENT RATES WERE NOT ALWAYS IN ACCORDANCE WITH FEDERAL REQUIREMENTS**

Some of the State agency's Medicaid payment rates for ISL habilitation services were not always in accordance with Federal requirements. Specifically, of the 3,170 payment rates (for 100 individuals) that we reviewed (footnote 6) in our stratified random sample, 347 of the payment rates included unapproved and unallowable costs.<sup>9</sup> The 347 payment rates in error accounted for \$381,656 (\$247,122 Federal share) in unapproved and unallowable Medicaid payments for the 100 individuals in our sample. This amount represents the difference between (1) the payment rates originally claimed by the State agency that improperly included unapproved and unallowable costs and (2) the payment rates that we recalculated without unapproved and unallowable costs.

### **The State Agency Included Unapproved Costs in Some of Its Payment Rates**

The unapproved costs consisted of costs included in the payment rate that were not listed in the ISL budget and, therefore, were not approved by DMH.

### **The State Agency Included Unallowable Costs in Some of Its Payment Rates**

The unallowable costs consisted of room-and-board costs. Examples of unallowable room-and-board costs included client food, telephone expenses, and rental property deposits, all of which appeared to be property-related costs.

Because the State agency included unapproved and unallowable costs in some of its payment rates for ISL habilitation services, and on the basis of our sample results, we estimate that it claimed unallowable Medicaid payments of \$2,185,638 (1,455,378 Federal share) during SFYs 2011 through 2013.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$1,455,378 to the Federal Government and
- follow Federal requirements when determining the payment rates for ISL habilitation services by including only costs that DMH has approved and by excluding unallowable costs.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency disagreed with our first recommendation and stated that it would continue to work to comply with Federal requirements and State agency guidance with respect to our second recommendation.

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<sup>9</sup> Of the 347 payment rates, 274 included unapproved costs and 73 included unallowable costs.

Regarding our first recommendation, the State agency said that the overwhelming majority of the costs (the State agency referred to these as budget line items) that we questioned were allowable expenditures authorized under Missouri’s developmental disabilities waiver. With respect to the administrative costs that we had categorized as unallowable, the State agency said that it was inappropriate for the Federal Government to disallow Federal funds based on noncompliance with State policies. The State agency added that we did not provide sufficient information to support our position that some costs were not approved by DMH. Finally, the State agency said that we based the amount of disallowed costs in our draft report’s first recommendation on an extrapolation of our conclusion that approximately 2 percent of the reviewed costs were unallowable or unapproved. According to the State agency, “Extrapolating a disallowance based on such a small error rate is inconsistent with [F]ederal policies.” The State agency supported this assertion by citing Federal regulations pertaining to quality control programs in Medicaid and in Aid to Families with Dependent Children.

A summary of the State agency’s specific comments and our responses follows. The State agency’s comments appear in their entirety in Appendix E.

After reviewing the State agency’s comments, we identified within them those pieces of information and explanation that had not previously been given to us, and we revised some of our findings and adjusted the dollar amount in our first recommendation accordingly. Otherwise, though, we maintain that our findings and recommendations, as they appear in this final report, are valid. We based our extrapolation (that is, our projection) on the dollar value of the errors in our sample to appropriately estimate the overall value of the sampling frame. The State agency’s comments indicated a misunderstanding of Federal policy regarding extrapolation and relied on regulations that are not applicable to the Medicaid HCBS waiver program or to the Office of Inspector General (OIG) and, in the case of one of those quality control programs, relied on a regulation that is no longer in effect.

## **QUESTIONED COSTS CATEGORIZED AS UNALLOWABLE**

### **State Agency Comments**

The State agency’s comments identified 31 costs (or in the State agency’s terms, budget line items) that, according to the State agency, our draft report had identified as unallowable. The State agency said that the “overwhelming majority” of these questioned costs were allowable costs authorized under the developmental disabilities waiver. The State agency discussed the nature of these costs and offered some possible explanations of how and why the different methodologies with which ISL providers paid their employees may have caused those providers to use different terms for some of those costs when reporting them on an individual’s ISL budget.

For some of these 31 costs, the State agency said, in addition to the statements summarized above, that it disagreed with our findings because it is inappropriate for the Federal Government to disallow Federal funds based on noncompliance with State policies. We summarize and respond to this aspect of the State agency’s comments below in “Noncompliance With the State Agency’s Cap on Administrative Costs.”

## Office of Inspector General Response

The State agency's comments about the 31 costs were based, not on the information in our draft report or on the detailed data that we gave to the State agency a week before our exit conference, but rather, on a preliminary document that we prepared several months earlier, while we were still conducting fieldwork for this audit. The State agency replied to that preliminary document and, based on that information, we revised our listing of unallowable costs from the original 31 to 18. We provided that revised listing to the State agency, reviewed it with the State agency at the exit conference, and used it as the basis for the unallowable costs presented in our draft report. A detailed account of these circumstances follows.

The 31 costs to which the State agency's comments refer were included in a preliminary listing of unallowable costs that we provided to the State agency on December 9, 2014 (while we were still conducting fieldwork), to give the State agency an opportunity to explain whether or not the costs were allowable.<sup>10</sup> On February 17, 2015, the State agency provided explanations for 16 of the 31 costs and offered no explanations regarding the other 15 costs in that preliminary listing.

Based on the explanations, we removed 13 costs (of the 16 costs that the State agency addressed in its February 17, 2015, communication to us) from all of our subsequent calculations of unallowable costs. We retained 3 of the 16 costs (AP II, OTA, and OTC, all three of which involve psychologist and occupational services) in all of our subsequent calculations of unallowable costs. We did so because the State agency's February 17, 2015, communication to us stated that these costs should have been authorized as separate services. According to that communication, then, the costs should have been billed separately as needed and should not have been included in the monthly ISL payment rate.

We then provided the updated detailed listing of what was now 18 unallowable costs (AP II, OTA, and OTC costs, plus the 15 costs that the State agency did not address or explain in its February 17, 2015 response) to the State agency on April 10, 2015.<sup>11</sup> On the same date, we gave the State agency our updated calculation of the unallowable amount, supporting detail on the claims used in that calculation, and the projected unallowable amount. The State agency acknowledged its receipt of this information on April 13, 2015, but provided no further explanation regarding the 18 unallowable costs, either after that date or at our exit conference. The draft report upon which the State agency commented dealt with these 18 unallowable costs, not the 31 costs discussed in the State agency's written comments.

Those written comments gave us several pieces of additional information and explanation that had not previously been given to us. After reviewing the new explanations in those comments, we have removed 14 of the 18 costs from our calculations of unallowable costs for this final report. Specifically, we have recalculated the unallowable Medicaid payments based on the four remaining costs that we still regard as unallowable (beneficiary food, \$1 per day, rental property

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<sup>10</sup> This preliminary listing is the spreadsheet to which the State agency referred in the first two footnotes of its written comments.

<sup>11</sup> See also our response to "Costs Not Approved by the Missouri Department of Mental Health" later in this report.

deposit, and program supplies (telephone)) (the same four costs that the State agency agreed in its written comments were unallowable) and have adjusted the recommended refund amount in our first recommendation accordingly.<sup>12</sup>

## **NONCOMPLIANCE WITH THE STATE AGENCY’S CAP ON ADMINISTRATIVE COSTS**

### **State Agency Comments**

As mentioned earlier, part of the State agency’s disagreement with some of the costs we identified as unallowable derived from its contention that noncompliance with State policy is not an appropriate grounds for a Federal disallowance. The State agency also stated that there are no State laws or regulations that cap administrative expenses. In addition, the State agency said that even if Office of Management and Budget (OMB) Circular A-87, Appendix A, section C.1., authorizes disallowances for noncompliance with State law, it does not authorize a disallowance for noncompliance with State sub-regulatory guidance.<sup>13</sup> According to the State agency, “DMH’s cap on administrative expenses is not found in ‘state laws or regulations’; rather, it is in DMH’s 2008 sub-regulatory ‘Guidelines.’” Finally, the State agency said that OMB’s recent re-codification of its cost principles had eliminated “the provision of OMB A-87 on which the OIG presumably relies.”

### **Office of Inspector General Response**

We agree that Federal requirements do not provide specifications regarding the capping of administrative costs in the ISL budgets. In addition, we agree that even though the State agency enforces its ISL guidelines for the most part, we cannot apply the State agency ISL guidelines in our review as they were not specifically referred to in the HCBS waiver application.

Therefore, we have removed the unallowable administrative costs from our calculations and have adjusted the recommended refund amount in our first recommendation. We have also removed for this final report the reference to the State agency guidelines that appeared in the second recommendation of our draft report.

Finally, the elimination of the relevant OMB Circular A-87 provision when that Circular was codified and relocated to Federal regulations has no bearing on this audit or this finding. This Circular, which was codified at 2 CFR part 225, establishes principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments. The provision of OMB Circular A-87, Appendix A, section C.1., to which the

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<sup>12</sup> The 4 costs that we still regard as unallowable are associated with 4 of the 35 total individuals with unallowable payments (out of the 100 individuals in our statistically valid sample). See Appendix C as well as our related discussion in “Recommended Disallowance Based on Extrapolation” below.

<sup>13</sup> Office of Inspector General note: OMB Circular A-87, *Cost Principles for State, Local, and Tribal Government*, was relocated to 2 CFR part 225. After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

State agency referred in its comments states: “To be allowable under Federal awards, costs must meet the following general criteria: “... (c) Be authorized or not prohibited under State or local laws or regulations.”

Although it is true that this provision of OMB Circular A-87 was eliminated when the OMB Circulars were consolidated and relocated to 2 CFR part 200 (footnote 13), that action did not take place until *after* our audit period, which extended from July 1, 2010, to June 30, 2013. Thus, the regulatory provision in question was in effect during the entire period covered by our audit.

## **COSTS NOT APPROVED BY THE MISSOURI DEPARTMENT OF MENTAL HEALTH**

### **State Agency Comments**

With respect to our finding that some of the unallowable costs we identified were not approved by DMH, the State agency said that neither our draft report nor anything else we provided to the State agency specified which individuals’ ISL budgets were not approved by DMH or which costs were not listed in those ISL budgets. The State agency added that without more information, it could not respond to our findings, and stated that the recommended disallowance should be decreased accordingly.

### **Office of Inspector General Response**

As explained in our response to “Questioned Costs Categorized as Unallowable” earlier in this report, we provided an updated detailed listing of all ISL payment rates in error to the State agency on April 10, 2015. That detailed listing included a column comparing the MMIS payment rates to the approved ISL budget payment rates. In each case when the approved ISL budget payment rate was less than the MMIS payment rate, we considered the payment rate to be in error and the difference between the two payment rates to be unallowable because that difference represented costs that were included in the payment rate but that were not listed in the ISL budget that DMH approved. (We obtained the payment rates associated with the approved ISL budgets during our fieldwork at the State agency regional offices.) During and after our fieldwork, we asked the State agency several times for any additional ISL budgets to support the MMIS payment rates; none were provided.

## **RECOMMENDED DISALLOWANCE BASED ON EXTRAPOLATION**

### **State Agency Comments**

The State agency based its disagreement with our first recommendation, in part, on its disagreement with our sampling methodology. The State agency said that the amount of questioned costs in our sample represented approximately 2 percent of reviewed charges and that “[e]xtrapolating a disallowance based on such a small error rate is inconsistent with federal policies for analyzing and recouping overpayments.” The State agency also stated that our draft report found “that 56 of the 100 individuals sampled had budgets with at least one unallowable line item. But that does not mean that there was a 56 % error rate.”

The State agency cited another OIG audit report (A-05-08-00052) and added that, in the State agency's understanding, OIG policy is to not extrapolate findings if the error rate is below 5 percent.

The State agency further stated that the 2 percent error rate was also considerably lower than the tolerance levels established in various quality control programs in Medicaid and other federally funded programs, such as the Medicaid Eligibility Quality Control program (regarding which the State agency cited Federal regulations at 42 CFR § 431.865) and the Aid to Families with Dependent Children program (45 CFR § 205.41 (1980)).

### **Office of Inspector General Response**

Our report provides a fair and accurate description of the errors we observed during our audit. The State agency based its reference to 56 individuals with errors on a data element in Appendix C of our *draft* report. That number, as reflected in Appendix C of this *final* report, is now 35.<sup>14</sup> That figure appears alongside the dollar totals associated with those errors, and together these figures serve as a description of the sample results. The number of individuals with errors reflects the widespread nature of the problem but does not accurately communicate the magnitude of the financial effect of the unapproved and unallowable costs that this audit has identified. Our sampling methodology appropriately estimated the overall value of the sampling frame because we based our extrapolation on the dollar value of the errors, rather than on the number of individuals with errors. The State agency correctly noted that the estimated dollar amount of the errors made up a relatively small portion of the total reviewed amount. The State agency was incorrect, though, in asserting that this fact prevents us from extrapolating (that is, projecting) those results.

Moreover, the State agency's reliance on a previous OIG report in which the sample results were not extrapolated was based on a misinterpretation of an OIG policy that was, in fact, superseded before our audit period. In that previous report to which the State agency referred (A-05-08-00052), we found 3 errors in a sample size of 100. At the time of the audit period covered by that previous OIG report, it was OIG policy not to extrapolate sample results if the number of individual errors was five or fewer. (The dollar amount of the error was not relevant to this policy, and, at any rate, that extrapolation policy no longer exists.) For this current review, though, we found that 347 payment rates had errors, which corresponded to 35 of 100 sample beneficiaries having at least 1 error in their associated payment rates. The significantly higher number of errors (and the significantly higher percentage of sample beneficiaries whose associated payment rates had errors) in this current audit, combined with the change in our extrapolation policy since the audit period covered by that previous report, renders the State agency's arguments against extrapolation irrelevant. Extrapolation of our sample results in this instance was in fact appropriate and accorded with our current policy.

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<sup>14</sup> As discussed earlier, we removed some of the costs we had originally categorized as unallowable in response to the State agency's comments. These revisions reduced the number of individuals with at least 1 unallowable cost to 35.

The State agency also relied on regulations that are not applicable to the Medicaid HCBS waiver program or to OIG. Furthermore, in the case of one of the quality control programs that the State agency cited, the State agency relied on a regulation that is no longer in effect. The State agency cites tolerance limits in other Federal programs, such as the Medicaid Eligibility Quality Control program and the Aid to Families with Dependent Children (AFDC) program. However, the regulations and policies that apply to those programs do not apply to the Medicaid HCBS waiver program that was the focus of this audit; nor do those regulations and policies apply to us. Finally, the regulatory requirement cited by the State agency with respect to the AFDC program (45 CFR § 205.41) is no longer in effect.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

During SFYs 2011 through 2013 (July 1, 2010, through June 30, 2013), the State agency claimed Medicaid reimbursement totaling \$833,969,988 (\$549,979,719 Federal share) for ISL habilitation services. We reviewed a sample of 100 individuals who had 3,170 payment rates with associated Medicaid reimbursement of \$35,866,098 (\$23,698,171 Federal share) during the audit period.

We did not perform a detailed review of the State agency's internal controls because our objective did not require us to do so. We limited our review to the controls that pertained directly to our objective.

We conducted fieldwork at the State agency in Jefferson City, Missouri, and at State agency regional offices throughout Missouri, from August 2014 through March 2015.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements, the CMS-approved developmental disabilities waiver, and State agency ISL guidelines;
- held discussions with officials from the State agency and DMH to gain an understanding of the State agency's payment rate methodology for ISL habilitation services;
- reviewed MMIS claim payment data for ISL habilitation services provided and paid for in SFYs 2011 through 2013;
- reconciled the MMIS claim payment data for ISL habilitation services to the Medicaid payments claimed on the State agency's CMS-64 reports for SFYs 2012 and 2013;
- identified, from the SFYs 2011 through 2013 MMIS claim payment data, the individuals who received ISL habilitation services;
- reviewed a judgmentally selected sample of three individuals' ISL budgets used to calculate their ISL payment rates to determine whether costs reported were supported;<sup>15</sup>
- developed a sampling frame consisting of 4,636 individuals receiving ISL habilitation services (Appendix B) and determined that the sampling frame included MMIS claims totaling \$833,969,988 (\$549,979,719 Federal share) provided and paid for during SFYs 2011 through 2013;

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<sup>15</sup> All three of the individual ISL budgets that we reviewed had adequate support for their costs; we noted no major discrepancies with respect to these ISL budgets.

- selected a stratified random sample of 100 individuals who had received ISL habilitation services and, for each individual:
  - reviewed the costs included in the individual’s payment rates used during SFYs 2011 through 2013, removed unapproved and unallowable costs, and then recalculated the payment rates;
  - determined the associated allowable Medicaid payments by applying the recalculated payment rates to the actual MMIS claims for these services that were provided and paid for during SFYs 2011 through 2013;
  - determined the unallowable Medicaid payments by comparing the allowable Medicaid payments to the Medicaid payments that the State agency actually paid for these services during SFYs 2011 through 2013;
- estimated the unallowable Medicaid reimbursement (Appendix C); and
- discussed the results of our review with State agency officials on April 22, 2015.

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: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of the paid claims for the developmental disabilities waiver program during the period July 1, 2010, through June 30, 2013.

### SAMPLING FRAME

For our audit period, there were a total of 10,043,997 claims paid for ISL habilitation services under Missouri's developmental disabilities waiver.

From these claims, we removed certain claims as delineated and explained in the table below.

**Table: Type and Number of Claims Excluded From Sampling Frame**

<b>Claim Type</b>	<b>Claim Count</b>
Claims	10,043,997
ME Code 34 <sup>16</sup>	(13,229)
MFP Claims <sup>17</sup>	(68,713)
Procedure Code T2016HI Not Annotated <sup>18</sup>	(5,534,516)
Dates of Service Outside Audit Period	(138,265)
Claims With \$0 Reimbursement Amounts	(72)
<b>Claims Data File Total Claim Count</b>	<b>4,289,202</b>

From the remaining 4,289,202 development disabilities waiver claims, we created a sampling frame by individual. As a result, the sampling frame consisted of 4,636 individuals with associated payments totaling \$833,969,988 (\$549,979,719 Federal share) for ISL habilitation services.

### SAMPLE UNIT

The sample unit was one individual.

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<sup>16</sup> Claims associated with Medical Eligibility (ME) Code 34 are specific to the developmental disabilities children's waiver program and were therefore outside the scope of this review.

<sup>17</sup> Claims associated with Missouri's Money Follows the Person (MFP) demonstration grant, which supports people who have disabilities and those who are aging to move from nursing facilities or habilitation centers to quality community settings that meet their needs and wants, should be reported separately.

<sup>18</sup> Procedure Code T2016HI is the code specific to individual habilitation services under the developmental disabilities waiver; therefore, we removed all claims that did not have this procedure code.

## **SAMPLE DESIGN**

We used a stratified sample consisting of three strata. The strata was divided as follows, based on total individual reimbursement for the audit period:

- Stratum 1: 2,322 individuals whose individual total reimbursement for the audit period ranged from \$1 to \$174,999; reimbursements for these individuals totaled \$235,855,543 (\$154,700,612 Federal share).
- Stratum 2: 2,274 individuals whose individual total reimbursement for the audit period ranged from \$175,000 to \$517,999; reimbursements for these individuals totaled \$573,133,858 (\$378,751,307 Federal share).
- Stratum 3: 40 individuals with the highest individual total reimbursement amounts for the audit period, which ranged from \$518,000 to \$931,541; reimbursements for these individuals totaled \$24,980,587 (\$16,527,800 Federal share).

## **SAMPLE SIZE**

We selected a sample size of 100 individuals: 30 individuals from Stratum, 30 individuals from Stratum 2, and 40 individuals from Stratum 3.

## **SOURCE OF THE RANDOM NUMBERS**

We used the OIG, Office of Audit Services (OAS), statistical software to generate the random numbers.

## **METHOD FOR SELECTING SAMPLE ITEMS**

For Stratum 1 and Stratum 2, we consecutively numbered each sample unit. The following is the numbering for both:

- Stratum 1: 1 to 2,322
- Stratum 2: 1 to 2,274

After generating 30 random numbers per stratum, we selected the corresponding frame items.

For Stratum 3, we reviewed 100% of the 40 individuals in the stratum.

The total sample units from all 3 strata added up to 100.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the unallowable Federal Medicaid reimbursement by applying the applicable FMAP to the payments for ISL habilitation services whose payment rates included unapproved and/or unallowable costs.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Sample Details and Results**

<b>Strata</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Individuals with Unallowable Payments</b>	<b>Value of Unallowable Payments (Federal Share)</b>
1	\$154,700,612	30	\$1,907,992	6	\$22,519
2	\$378,751,307	30	\$5,262,379	13	\$19,896
3	\$16,527,800	40	\$16,527,800	16	\$204,707
<b>Total</b>	<b>\$549,979,719</b>	<b>100</b>	<b>\$23,698,171</b>	<b>35</b>	<b>\$247,122</b>

**Estimated Value of Unallowable Payments (Federal Share)**  
*(Limits Calculated for the 90-Percent Confidence Interval)*

Point Estimate	\$3,455,807
Lower Limit	\$1,455,378
Upper Limit	\$5,456,235

**APPENDIX D: FEDERAL REQUIREMENTS AND  
MISSOURI'S DEVELOPMENTAL DISABILITIES WAIVER REQUIREMENTS  
FOR INDIVIDUALIZED SUPPORTED LIVING HABILITATION SERVICES**

**FEDERAL REQUIREMENTS**

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

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

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

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

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

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

## MISSOURI'S DEVELOPMENTAL DISABILITIES WAIVER REQUIREMENTS

Missouri's CMS-approved developmental disabilities waiver (footnote 3), Appendix I ("Financial Accountability"), states:

Individualized supported living [payment] rates are individually set. A budget is developed for each waiver participant who receives individualized supported living (residential) services. The provider develops a budget based on the individual's needs as described in the individual service plan. The regional office [DMH] reviews the proposed budget, makes adjustments if needed, and approves the final budget which is developed to a [payment] rate.

The developmental disabilities waiver also states that payment rates for ISL habilitation services do not include room-and-board costs. Room and board is paid directly to the provider by DMH using State-only funds. Specific costs listed as ineligible in the developmental disabilities waiver include costs associated with rent, utilities, food, clothing, insurance, housekeeping, communications, buildings, and land. In addition, the developmental disabilities waiver states: "[Payment] [r]ates for residential services and individualized supported living are negotiated between the provider and the Department of Mental Health in accordance with Department procedures and policies for [payment] rate setting. [Payment] [r]ates are based on a daily rate."

The developmental disabilities waiver, Appendix C ("Participant Services"), lists allowable costs that can be included in the payment rates for ISL habilitation services as:

Direct Support, which includes:

Direct Support Staff

Professional management, responsible for:

- Staff training and supervision;
- Quality enhancement monitoring;
- Direct plan implementation for individuals as needed;
- Monitoring implementation of outcomes;
- Establishing information collection systems;
- Writing monthly reviews;
- Oversight/coordination of all the person's programs and services being received; and

- Coordinating the development of the individual service plan (scheduling, facilitation and summary document).

#### Travel

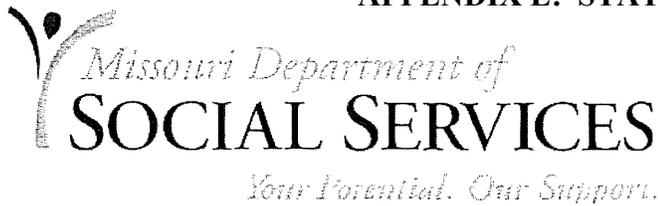
#### Back-up and safety net supports, which include

- Maintenance of phone number which will be answered 24 hours and to assure a regular point of contact for the person supported;
- Provide a back-up plan should other supports fail to materialize as planned; and
- Assuring communication regarding changes in the person's life (health, behavior, employment, etc.), with those important to the individual, including but not limited to: Family/guardians, educational staff, employer, day program, case manager, physicians, etc.

#### Monthly Registered Nurse oversight

#### Administrative costs

APPENDIX E: STATE AGENCY COMMENTS



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August 19, 2015

Patrick J. Cogley  
Regional Inspector General for Audit Services  
Office of Audit Services, Region VII  
Office of Inspector General  
U.S. Department of Health and Human Services  
601 East 12th Street, Room 0429  
Kansas City, MO 64106

Re: Draft Audit Report A-07-14-03202

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 Unallowable Medicaid Payments for Individualized Supported Living Habilitation Services*, A-07-14-03202 (July 2015) (hereafter "Draft Audit Report").

The Missouri Department of Social Services ("DSS" or "Missouri") disagrees with the OIG's draft recommendations that the State should return \$4,524,148 to the federal government. As explained below, the overwhelming majority of the budget line items questioned by the Draft Audit Report were allowable expenditures authorized under Missouri's Developmental Disabilities (DD) Comprehensive Waiver. In addition, the disallowance recommendation is based on an extrapolation of the OIG's conclusion that approximately 2% of the federal funds claimed in the sample were unallowable or unapproved. Extrapolating a disallowance based on a sample with such a low error rate is inappropriate and inconsistent with federal policies.

The Missouri Department of Mental Health (DMH) is the lead agency operating Missouri's Section 1915(c) DD Comprehensive Waiver. Waiver services include, among other things, in-home respite, individualized supported living (ISL) habilitation, job preparation, personal care, behavior analysis, community specialist services, community transition, assistive technology, counseling, crisis intervention, host home, independent living skill development, occupational therapy, person centered strategies consultation, and professional assessment and monitoring. See Application for a §1915(c) Home and Community-Based Services Waiver, Developmental Disabilities Comprehensive Waiver, App'x C, C-1 (July 1, 2011) (listing services provided under the DD Comprehensive Waiver) (hereafter "Waiver Application").

Under this waiver, some enrollees receive home- and community-based services through individualized supported living (ISL) provider agencies. These ISL provider agencies deliver more than just ISL habilitation; they often deliver and/or coordinate most or all of an enrollee's waiver services.

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See Waiver Application, *supra*, App'x C, C-1/C-3 (indicating that Independent Living Skills Development, Behavior Analysis, Community Employment, Crisis Intervention, and other services may be provided either inside or outside of the ISL budget, as long as there is no duplication).

The State makes per diem payments to ISL provider agencies for the cost of providing these waiver services to enrollees. The per diem payments are based on a monthly budget of the provider agency's cost of providing services to the specific enrollee. ISL budgets are broken into line items describing the services to be provided. The ISL provider agency proposes a budget based on the enrollee's needs and submits it to DMH for review. DMH then "reviews the proposed ISL budget, makes adjustments if needed, and approves the final ISL budget." Draft Audit Report, *supra*, at 2. DSS uses the final, approved monthly budget to calculate an enrollee-specific per diem rate, which the provider agency is paid for providing services to the enrollee. *Id.* The provider agency reviews the budgets periodically to see if any changes are warranted, based on changes to the enrollee's condition and needs.

The OIG reviewed the ISL budgets for 100 waiver enrollees in a stratified random sample, as well as the associated payment rates for the services provided and paid during state fiscal years (SFY) 2011 through 2013. According to a spreadsheet the OIG provided the State, the OIG identified 31 different line items in the budgets that represented unallowable costs. See Table 1.<sup>1</sup> All of the line items questioned by the OIG were reported in the budgets under the umbrella of "other" costs. The Draft Audit Report also concluded that several individuals' budgets included administrative costs in excess of DMH's policy of capping administrative expenditures at the lesser of 15% or \$800. Between the line items that the OIG asserts represented unallowable costs, and the administrative costs that the OIG claims exceeded the State's cap, the Draft Audit Report asserts that one or more line items in at least one of the monthly budgets for 56 of the 100 sampled individuals was not allowable under state or federal rules or policies. In addition, the Draft Audit Report asserts that the State reimbursed provider agencies for some costs "that were not listed in the ISL budget and, therefore, were not approved by DMH."

These purportedly unallowable or unapproved line items represented \$525,126 (federal share),<sup>2</sup> which was approximately 2% of the dollar value of the claims in the OIG's sample (\$23,698,171 in federal share). Although the OIG found that only a small fraction of the line items in the sample were unallowable, the Draft Audit Reports nonetheless extrapolated its findings onto the entire population of claims made during the three-year audit period (\$549,979,719 in federal share). The OIG states that this extrapolation yielded a \$4,524,148 (federal share) disallowance recommendation.

### **1. The Overwhelming Majority of the Line Items Questioned by the Draft Audit Report Described Costs Allowable under the DD Comprehensive Waiver.**

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<sup>1</sup> The Draft Audit Report does not mention many of the specific line items questions by the OIG. DSS's understanding about what line items were found unallowable is based on a spreadsheet provided to DMH by the OIG on December 9, 2014.

<sup>2</sup> The detailed spreadsheet the OIG provided to the State on December 9, "Sample Items with Errors", appears to indicate that the allegedly unallowable costs total \$538,270.43 in federal share (\$433,708.95 in unallowable line items (column CN), \$87,899.55 in unallowable administrative costs (column CL) and \$16,661.94 in rate discrepancies (column CJ)). The spreadsheet also lists the budgets of only 88 individuals, as opposed to the 100 individuals apparently sampled. However, another spreadsheet the OIG provided on December 9, "Unallowable Amounts", confirms that the unallowable costs in fact totaled only \$525,156 and appears to have different unallowable amounts for the sampled individuals than the "Sample Items with Errors" spreadsheet. DSS requests that the OIG explain these apparent inconsistencies.

The overwhelming majority of the line items questioned in the draft audit report were for allowable costs, and the disallowance recommendation should be reduced accordingly.

Specifically, 27 of the 31 questioned line items were allowable:

Table 1

State's Position About Line Items Questioned by the OIG	
Allowable Costs	Unallowable Costs
<ul style="list-style-type: none"> <li>• Add'l admin</li> <li>• AP II</li> <li>• OTA</li> <li>• OTC</li> <li>• Homemaker</li> <li>• Alarm</li> <li>• Qtr day placement</li> <li>• House manager</li> <li>• Direct care retention</li> <li>• Program supplies</li> <li>• Life skills coord</li> <li>• Temp rate increase SB40</li> <li>• Team leader admin</li> <li>• Staff meeting hours</li> <li>• Behavior sticker money</li> <li>• Companion ren</li> <li>• Respite</li> <li>• Primary staff</li> <li>• BSP reinforcers</li> <li>• Transition costs</li> <li>• Sleep staff</li> <li>• Live-in/night call</li> <li>• Community inte</li> <li>• Qtr act expense</li> <li>• Sick days</li> <li>• Professional manager</li> <li>• Program supplies (behavior strategies)</li> </ul>	<ul style="list-style-type: none"> <li>• Bene food</li> <li>• \$1 per day</li> <li>• Rental property deposit</li> <li>• Program supplies (phone)</li> </ul>

**a. Twelve Line Items Questioned by the Draft Audit Report are for Allowable Direct Care Costs.**

The Draft Audit Report rejects twelve line items, listed under "other" services that represent allowable direct service costs:

- "Sick days" is the cost of providing sick days to direct care workers.

- “AP II” is the cost for Associate Psychologists to perform behavior analysis, counseling, and/or crisis intervention authorized under the waiver. See Waiver Application, *supra*, App’x C, C-1/C-3 (authorizing behavior analysis services, counseling, and crisis intervention, and outlining the qualifications for individuals delivering the service).
- “OTA” and “OTC” is the cost for occupational therapists to provide occupational therapy authorized under the waiver. See *id.* (authorizing occupational therapy).
- Homemaker services is the cost for workers to provide homemaker services authorized under the waiver. See *id.* (authorizing respite provided by homemaker providers and personal care services).
- “Community Inte” is the cost for workers to provide community integration training authorized under the waiver. See *id.* (authorizing community integration as part of residential habilitation, host home, and/or independent living skills development); see also DMH, Guidelines for Funding Individualized Supported Living, at 4 (Jan. 2008) (hereafter “DMH Guidelines”) (explaining that direct care community integration skills trainers, and community specialists supervising community integration skills trainers, are reimbursable residential habilitation services).
- Respite services are authorized under the waiver. See Waiver Application, *supra*, App’x C, C-1/C-3.
- “Sleep staff” is the cost for workers to spend the night at the enrollee’s home.
- “Companion Ren” is the cost of rent for staff to live in an enrollee’s home, as authorized by the waiver, see *id.*, App’x I, I-6.
- “Temp rate increase SB40” is the cost of increased wages for direct care workers. “SB-40 Boards” are county boards that provide services to individuals with intellectual and developmental disabilities. For part of the audit period, the SB-40 Boards had funded increased wages for direct care workers. “Temp rate increase SB40” is the cost of the provider agencies paying the increased wages to the workers.
- “Direct Care Retention” is for increased payments for workers to retain workers.
- “Primary Staff” is the cost of additional, 2:1 specialized staff to assist enrollees who had frequent behavior outbursts. These staff members worked closely with enrollees and families to coordinate a range of services.

It appears that some provider agencies listed some of these direct care costs as “other” costs, instead of as direct care costs, because they were wages for workers who were paid differently than other workers providing similar services. Provider agencies calculate their line items for direct care costs by multiplying the number of hours worked by the hourly payment for the type of service. For example, provider agencies calculate “community inte” worker costs by multiplying the number of hours of training services by the set hourly rate that they pay for the training workers. If a provider agency is paying a worker a different wage or rate than it generally pays workers for providing the same category

of services, the cost of the worker paid differently cannot be listed on that direct care line item, and therefore reporting the cost as "other" is an appropriate mechanism for accurately reporting the cost. For example, some overnight workers are paid a different (lower) rate than the standard rate for paid sleep. The cost of those overnight workers is therefore reported as "sleep staff" under "other" costs, instead of as a "paid sleep" cost or a "Direct Service (Sleep)" cost.

Some of the allowable direct care costs that were listed as "other" costs probably should have been reported as a direct care cost. But to the extent the provider agencies erred in their cost reporting, these reporting errors did not impact the provider agencies' reimbursement in any way because provider agencies are fully reimbursed for all allowable costs, regardless whether they are listed as direct care costs or as "other" costs.

**b. Two Line Items Questioned by the Draft Audit Report are for Allowable Administrative Expenses.**

The Draft Audit Report also questions two "other" line items that reflect allowable administrative costs. Specifically, "add'l admin" and "staff meeting hours" (costs associated with staff meetings regarding the delivery of direct care to enrollees) represent valid administrative costs.

It is possible that, if reported as administrative costs in the budgets (instead of as "other" costs), part of these costs would have exceeded DMH's 15%/\$800 limit on administrative expenses. Even if that is the case, however, it is inappropriate for the *federal* government to take a disallowance of federal funds based on noncompliance with *state* policies, see *infra* Section 2. And, where these administrative costs would not have exceeded the State's cap on administrative costs, reporting them as "other" costs had no impact whatsoever on the reimbursement that the provider agencies received.

**c. Thirteen Line Items Questioned by the Draft Audit Report are for Other Allowable Costs.**

The Draft Audit Report rejects thirteen line items that represent allowable costs that were properly listed under "other" expenses in the ISL budgets:

- "Professional manager", "house manager", "team leader admin", and "life skills coord" are all for the cost of managing, scheduling, and training staff providing direct care services. Different providers and different regions use different terms to describe this cost. As the OIG acknowledges in its draft audit report, the waiver expressly lists "professional management" as an allowable cost. Draft Audit Report, *supra*, at 4.<sup>3</sup>
- "Alarm" and "live-in/night call" are the technology and staffing costs associated with remote monitoring of an enrollee at night, in lieu of direct care workers sleeping in the enrollee's home. For example, one provider agency (Woodhaven ISL) paid for Lifeline for enrollees, and listed that cost under "Alarm." This type of remote monitoring is contemplated and authorized by the waiver as an assistive technology service, and it is a cost effective way to ensure enrollees' safety overnight. See Waiver Application, *supra*, App'x C, C-1/C-3.
- "Program Supplies" and "Qtr act expense" are the miscellaneous costs for chaperoned community activities. For example, the price of a ticket when taking an enrollee into the community for a

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<sup>3</sup> Unlike other managers, staff listed as life skills coordinators may also provide direct services to enrollees.

movie. (When this cost is listed as "Qtr act expense", it is billed on a quarterly basis, as opposed to a monthly basis.)

- "Behavior sticker money", "BSP reinforcers", and "Program supplies (behavior strategies)" are the costs of supplies to provide rewards to enrollees for positive behaviors (e.g., stickers, ice cream). The waiver authorizes the State to provide "behavior analysis" to assist an enrollee learn and improve behavior. Behavior analysis includes the "design, monitoring, revision and/or brief implementation of 1:1 behavioral interventions described in the individual's behavior support plan." *Id.* Rewards are a tool used to improve behavior and they are allowable costs if included in the enrollee's behavior support plan.
- "Transition costs" is the cost of providing one-time set-up expenses to waiver enrollees transitioning out of an institutional setting. Examples of allowable "community transition" costs include: transportation of belongings to a new home, furnishing of new home, and health and safety measures such as pest eradication or allergen control. *Id.* Transitioning individuals from institutional settings into the community is a key objective of the DD Comprehensive Waiver. See *id.* § 2.
- "Qtr day placement" is the cost of additional hours that the provider agencies incurred because a worker was unexpectedly absent (e.g., sick).

## **2. Noncompliance with the State's Cap on Administrative Costs is Not an Appropriate Grounds for a Federal Disallowance.**

Part of the disallowance is based on the OIG's allegation that some of the payments failed to comply with state agency guidance. Specifically, the OIG alleges that several ISL budgets included administrative costs in excess of DMH's policy of capping administrative expenditures at the lesser of 15% or \$800, see DMH Guidelines, *supra*.

Noncompliance with state policy is not an appropriate grounds for a federal disallowance. As far as DSS is aware, the only authority on which the OIG has relied to justify recommending disallowances based on noncompliance with state requirements is Section C.1 of Appendix A of Office of Management and Budget (OMB) Circular A-87, which reads in part: "To be allowable under Federal awards, costs must . . . Be authorized or not prohibited under State or local laws or regulations." (Neither OMB Circular A-87 nor any other federal rule or policy is cited in the Draft Audit Report to justify taking a disallowance of federal funds based on noncompliance with state law.)

Assuming *arguendo* that this provision of OMB Circular A-87 authorizes disallowances for some types of noncompliance with state law, it does not authorize a disallowance for noncompliance with state sub-regulatory guidance. The provision only requires that the costs be authorized or not prohibited by state or local "laws or regulations." DMH's cap on administrative expenses is not found in state "laws or regulations"; rather, it is in DMH's 2008 sub-regulatory "Guidelines."

In any event, the provision of OMB A-87 on which the OIG presumably relies was eliminated by OMB in its most recent re-codification of its cost principles.<sup>4</sup> See 78 Fed. Reg. 78590 (Dec. 26, 2013). Elimination of this requirement provides a strong justification for not pursuing a disallowances based on

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<sup>4</sup> We have attached a document comparing the relevant provisions of OMB A-87 to the current regulations.

noncompliance with state requirements. OMB itself has apparently concluded that the federal government does not have an interest in enforcing compliance with state laws. This decision makes sense in light of the problematic policy implications of federal enforcement of state law. For example, penalizing a State for failing to comply with its own rules discourages States from establishing robust regulatory regimes to help ensure that high-quality health care is safely delivered to Medicaid beneficiaries.

**3. *The OIG has not Provided Sufficient Information to Support its Position that the Sample Included Costs not Approved by DMH.***

The Draft Audit Report asserts that part of the disallowance recommendation was based on the OIG's conclusion that the State reimbursed provider agencies for some costs "that were not listed in the ISL budget and, therefore, were not approved by DMH."

Neither the Draft Audit Report nor anything else provided by the OIG to the State specifies which individuals' budgets were not approved by DMH (if any) and/or which costs were not listed in the ISL budget. And, in fact, the spreadsheet the OIG provided the State seems to indicate that over 99% of the \$525,126 (federal share) in rejected costs was the result of line items that the OIG found unallowable (not unapproved). See note 2.

Without more information, it is impossible for the State to respond to the OIG's claim that its payments to the provider agencies included costs that DMH had not approved. Because the OIG has not provided evidence or documentation of this position, and therefore has not given the State a meaningful opportunity to respond, the disallowance should be decreased to the extent it relies on this part of the OIG's findings.

**4. *An Extrapolated Disallowance is Inconsistent with Federal Policies.***

As explained above, the OIG reviewed thousands of ISL budget line items totaling \$23,698,171 in federal share. Of that \$23.7 million covered by the sample, the Draft Audit Report questions only \$525,126 (federal share), representing approximately 2% of the reviewed charges.

Extrapolating a disallowance based on such a small error rate is inconsistent with federal policies for analyzing and recouping overpayments.

As DSS understands it, the OIG has a policy of not extrapolating sample findings if the error rate is below 5%.<sup>5</sup> The Draft Audit Report asserts that 56 of the 100 individuals sampled had budgets with at least one unallowable line item. But that does not mean that there was a 56% error rate. Most sampled individuals had over a dozen monthly budgets, and each monthly budget generally had several line items. The overwhelming majority of the line items in the sample were for costs that the OIG does not question; significantly less than 5% (approximately 2%) of the expenditures in the disallowance were rejected in the Draft Audit Report.

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<sup>5</sup> See, e.g., OIG, *Review of the Ill. Dep't of Pub. Health's Compliance with the Ryan White CARE Act Payer-of-Last-Resort Requirement*, A-05-08-00052 (Feb. 2009) (where 97 of 100 sample prescriptions were found to be correctly claimed, recommending recoupment only of the cost of the three incorrect sample prescriptions and not extrapolating onto the entire population).

This 2% error rate is also considerably lower than the 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% tolerance limit for eligibility errors in the Medicaid Eligibility Quality Control program); 45 C.F.R. § 205.42 (1980) (establishing a 4% tolerance limit for payment errors in the Aid to Families with Dependent Children program). In these programs, it is federal policy to seek recovery only for specific overpayments actually identified, when overall performance is within the established tolerance limits, and not to extrapolate the results of a review to the caseload as a whole. That policy should be applied in this case, where the level of allegedly erroneous payments is as low as it is.

**5. *The State Will Follow Federal Requirements and State Agency Guidelines.***

The State will continue to work to comply with federal requirements and state agency guidance when making payments to provider agencies in the DD Comprehensive Waiver.

Thank you for the opportunity to comment on this draft report. Please submit them in writing to this office.

Sincerely,



Brian D. Kinkade  
Director



Attachment

cc: James Scott  
Greg Tambke

## Comparison of Prior and Current Versions of OMB Circular A-87

### Prior Version

OMB A-87, 2 C.F.R. Part 225, App'x A, Section C.1 (2013):

#### C. Basic Guidelines

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
  - f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
  - g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
  - h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
  - i. Be the net of all applicable credits.
  - j. Be adequately documented.

### Current Version

2 C.F.R § 200.403 Factors affecting allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards:

- (a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
- (b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
- (c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
- (d) Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
- (e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
- (f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
- (g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.