Office of Missouri State Auditor

Nicole Galloway, CPA

Home and Community Based Services

Report No. 2018-125
December 2018

auditor.mo.gov

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CITIZENS SUMMARY

Findings in the Review of Home and Community Based Services

Trends in Expenditures and Assessments and Reassessments	Average annual costs per participant have increased every year from fiscal year 2014 to 2017 as expenditure growth has outpaced caseload growth. The numbers of assessments and reassessments performed annually has increased, and providers are performing an increasing share of reassessments.
Budgetary Estimates	Department of Health and Senior Services budgetary estimates of proposed program eligibility changes were not reasonable and resulted in overestimated cost savings projections for the Level of Care threshold change.
Level of Care Scores and Authorized Services	The Department of Health and Senior Services lacks an effective system to identify individuals most in need of services for eligibility purposes and to score the severity of need among participants when determining the appropriate amount of services authorized.
Provider Overpayments	Weaknesses in the Department of Health and Senior Services and MO Healthnet Division systems prevent the proper execution of MO Healthnet Division system edits to timely detect and prevent overpayments to some providers.

In the areas audited, the overall performance of this entity was **Good**.*

*****The rating(s) cover only audited areas and do not reflect an opinion on the overall operation of the entity. Within that context, the rating scale indicates the following:

Excellent: The audit results indicate this entity is very well managed. The report contains no findings. In addition, if applicable, prior recommendations have been implemented.

Good: The audit results indicate this entity is well managed. The report contains few findings, and the entity has indicated most or all recommendations have already been, or will be, implemented. In addition, if applicable, many of the prior recommendations have been implemented.

Fair: The audit results indicate this entity needs to improve operations in several areas. The report contains several findings, or one or more findings that require management's immediate attention, and/or the entity has indicated several recommendations will not be implemented. In addition, if applicable, several prior recommendations have not been implemented.

Poor: The audit results indicate this entity needs to significantly improve operations. The report contains numerous findings that require management's immediate attention, and/or the entity has indicated most recommendations will not be implemented. In addition, if applicable, most prior recommendations have not been implemented.

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Honorable Michael L. Parson, Governor
and
Dr. Randall W. Williams, MD, FACOG, Director
Department of Health and Senior Services
and
Dr. Steve Corsi, Psy.D., Director
Department of Social Services
Jefferson City, Missouri

We have audited certain operations of the Department of Social Services and Department of Health and Senior Services related to the administration of in home, consumer directed, and adult day care services. These services, collectively referred to as home and community based services (HCBS), provide assistance to disabled and elderly Medicaid-eligible citizens in their home or community based setting to help the participant remain living in the least restrictive setting possible. Participants are eligible for HCBS when they have been assessed to need a threshold nursing facility level of care (LOC) and are Medicaid-eligible. Beginning July 1, 2017, the state increased the LOC threshold to reduce the number of participants and reduce costs. The objectives of our audit were to:

1. Analyze data on HCBS authorized and paid, and evaluate the key factors influencing the data.

2. Determine the factors that have caused growth in participation and costs related to HCBS.

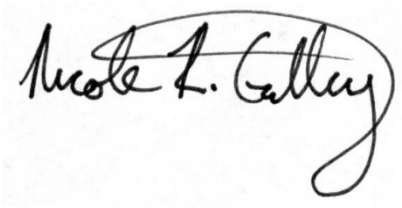
3. Determine whether the change in LOC is having the intended effect.

4. Evaluate the economy and efficiency of certain management practices and operations as it relates to HCBS.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our 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 such a basis.

For the areas audited, we identified (1) the LOC score does not effectively capture some aspects affecting participants' needs limiting its usefulness as an eligibility threshold and management tool, units of authorized services differ regionally for participants with similar LOC scores, providers have become increasingly involved in reassessments of participants, and some providers billed and received payments for more unit of service than authorized, (2) expenditures have grown due to increases in the number of participants, provider reimbursement rates, and units of authorized services in participant care plans, (3) the LOC threshold increase resulted in less cost savings than expected because the DHSS budget estimates did not consider the historical reassessment inflation rates in LOC score, and most of the participants with low LOC scores before the threshold change were reassessed at higher LOC scores after the threshold change and remained eligible for the HCBS, and (4) budget estimates of fiscal year 2018 cost savings did not consider historical increases in LOC scores and were overestimated, and the DHSS has made recent efforts to improve the processes for assessments and reassessments and care plans.

The accompanying Management Advisory Report presents our findings arising from our audit of the administration of the HCBS program.



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Home and Community Based Services Introduction

Background

In home services (IHS),[1] consumer directed (CD) services, and adult day care (ADC) services, collectively referred to as home and community based services (HCBS), assist in meeting the unmet needs of participants to allow them to remain in the least restrictive environment.

Medicaid

HCBS services are Medicaid funded and participants must meet the income limits requirements of that program. Medicaid is a joint federal and state program. The state share of Medicaid expenditures ranged from about 36 percent to about 38 percent during the period from fiscal year 2014 through fiscal year 2018. Most HCBS are authorized through the state's Medicaid plan, which is approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Medicaid program. Certain HCBS, including adult day care and homemaker services, are authorized through Medicaid waivers, which allow the state to target those services at certain populations. Medicaid waivers are approved by CMS.

Services

The primary HCBS available to participants are as follows:

- Personal care (PC) services are generally medically oriented tasks to meet the maintenance needs of persons with chronic health conditions. PC services may include tasks related to dietary, dressing/grooming, bathing, toileting, mobility/transfer, self-administration of medication, and medically related household tasks.

- CD services provide assistance with activities of daily living to individuals with disabilities who are able to direct their own care. Examples of CD services include bathing, cleaning, and meal preparation.

- Homemaker services are short-term tasks to help maintain a clean, safe home environment and include cleaning, laundry, meals, and shopping.

- Respite services are maintenance and supervisory tasks provided to a participant to provide temporary relief for the caregiver of the participant.

- Home delivered meals provide participants with up to 2 prepared meals per day delivered to their home.

- Adult day care (ADC) provides participants with continuous care and supervision in a licensed adult day care setting. Services include but are not limited to assistance with activities of daily living, planned group

[1] IHS administered by the Department of Health and Senior Services Division of Community and Public Health are excluded from this report as noted in the Scope and Methodology section.

activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation.

- Registered nurse (RN) services are for enhanced supervision of the personal care aide and maintenance or preventative services.

All HCBS other than CD services and ADC services are considered IHS. IHS and ADC services are delivered by staff of provider agencies contracted to provide services through the Missouri Medicaid Audit and Compliance (MMAC) unit. Staff members providing the services must meet certain training and experience requirements and cannot be related to the participant. For CD services, the participant selects and trains the individual (cannot be the individual's spouse) to provide the authorized services, and a vendor contracted with the MMAC acts as a conduit to process billings and payments and oversee the provider. To be eligible for CD services, the Department of Health and Senior Services (DHSS) must determine as part of the assessment process that the participant is capable of self-directing his/her care. Recipients of homemaker, chore, respite, and home delivered meals must be 63 years or older.

Services received by participants vary. Most participants receive either PC or CD services, but not both. Many IHS participants also receive RN services. Some participants may receive ADC services rather than, or in addition to, PC or CD services. Some PC participants may also receive homemaker, respite, and/or delivered meals. Table 1 shows fiscal year 2017 authorization information for the most popular services received by participants.

Table 1: Monthly authorized units, participants, and average units per participant, by service during fiscal year 2017

Service	Unit basis	Total monthly authorized units	Total participants receiving authorization	Average monthly units authorized per participant
Adult day care	15 minutes	1,646,952	2,727	604
Delivered meal	1 meal	316,750	10,246	31
Homemaker	15 minutes	306,184	3,785	81
Consumer directed	15 minutes	14,016,380	35,468	395
Personal care	15 minutes	5,668,858	25,869	219
Respite	15 minutes	1,080,905	4,689	231
Registered nurse	1 visit	98,768	30,868	3

Source: Number of units and participants based on SAO analysis of DHSS participant database

CD and PC services comprise most of the cost of HCBS. For example, payments for CD and PC services delivered during December 2017 represented 60 percent and 23 percent, respectively, of total HCBS payments. During fiscal year 2018, payments for CD services totaled about $469 million, and payments for IHS and ADC services totaled about $336 million.

The total cost of services rendered to any participant[2] cannot exceed the average annual Medicaid nursing facility cost per resident. Reimbursement rates for each service are determined annually as part of the process for determining the state appropriations to pay for the services. In addition, other limits are placed on the number of authorized services for some services. For fiscal year 2017, the reimbursement rates and limits for the most popular services were as follows:

Table 2: Unit reimbursement rates and limits, by service, fiscal year 2017

Service	Unit reimbursement rate	Unit limits
Adult day care	$2.33	200 units per week
Delivered meal	$5.91	2 meals per day
Homemaker	$4.60	690 units per month
Consumer directed	$4.01	791 units per month
Personal care	$4.60	414 units per month
Respite	$4.10	32 units per day
Registered nurse	$44.35	1 visit per day

Source: DHSS HCBS Policy Manual

Level of care

DHSS staff perform assessments of potential participants to determine the person's care needs and calculate a level of care (LOC) score. The LOC score is used to determine eligibility for HCBS or alternatively, if the participant chooses, for nursing facility residency. Prior to fiscal year 2018, individuals receiving LOC scores of 21 or higher were eligible for HCBS. The DHSS established 9 categories over which to evaluate the needs of the client and determine the overall LOC score. The categories are:

- Monitoring
- Medications
- Treatments
- Restorative
- Rehabilitative
- Personal care
- Dietary
- Mobility
- Behavior and mental condition

Based on the severity of the individual's needs, the individual receives a score of 0, 3, 6, or 9 on each of these categories, so the potential overall LOC scores range from 0 to 81. For fiscal year 2017, about 87 percent of CD services participants received scores between 21 and 39.

[2] Average costs for all waiver participants may not exceed the average nursing facility cost per resident, but total costs for individual waiver participants may exceed the average nursing facility resident cost.

Assessments and care plans

DHSS staff generally meet with the potential participant in his/her home to assess needed services. The DHSS utilizes an assessment form and system developed by a not-for-profit organization and modified to fit DHSS's 9 categories of need. The form requires the DHSS obtain information about the person's condition and make judgments about the severity of his/her disability. Much of the form requires the assessor enter numeric values to code the assessed degree of impairment of the individual currently and over the 3 days preceding the assessment. The form is divided into sections on cognition, communication and vision, mood and behavior, psychosocial well-being, functional status, continence, disease diagnosis, health conditions, oral and nutritional status, skin condition, medications, treatment and procedures, responsibility, social supports, environmental assessment, discharge potential, and overall status. Much of the information to complete the form is obtained from questions to, and observations of, the potential participant. Information can also be obtained from the person's family or other care providers. After the assessor completes the electronic assessment form, the system uses the data to calculate the LOC score for each category and the overall LOC score.

For those potential participants with overall LOC scores meeting or exceeding the LOC threshold and choosing to receive HCBS, the DHSS works with the participant to determine the types of services needed, the amount of time needed for the services, and their frequency. Those considerations are used to determine a plan of care for the participant detailing the monthly units of authorized services. The authorized services are generally effective for one year after authorization. The participant may choose the provider of the services. In developing the plan for authorized services, DHSS policy provides guidance to the assessor including the following:

- Consider the unmet needs of the participant.
- CD services cannot be authorized for services that members of a household may reasonably be expected to share or do for one another.
- When determining authorized services and tasks, consider formal/informal supports (authorized HCBS should not replace or duplicate existing supports) and costs of care.
- When determining the amount of time and frequency required for authorized tasks, consider the size of the home, geographic location, specific participant limitations, and formal/informal supports.
- Care plans among participants should generally reflect standard responses to similar problems.
- Suggested ranges of minutes needed and frequencies for common services tasks for typical participants.

At least annually a reassessment must be performed of each participant using the same process and form as the initial assessment. DHSS staff and provider agency staff share in the reassessment workload. DHSS personnel assign

reassessments to providers, and they review these reassessments and care plans for approval. DHSS personnel provide one-time training to designated individuals of certain provider agencies who are then responsible for training other staff of provider agencies involved in performing reassessments. Currently, DHSS has certified 550 individuals from 363 agencies as reassessment trainers. Provider agencies receive $75 per completed reassessment. Providers began performing reassessments in fiscal year 2011 to help alleviate a backlog of overdue reassessments. The backlog was eliminated in fiscal year 2016. DHSS personnel may complete certain reassessments by telephone call to the participant rather than an in-person visit.

Agencies involved

The DHSS, Department of Social Services (DSS), and provider agencies are involved in the process of determining eligible participants and authorizing, delivering, and paying for services to participants.

The Division of Senior and Disability Services (DSDS) within the DHSS is responsible for determining whether potential and current participants meet the LOC standard and authorizing services for the participants. Participants are assigned to one of 5 geographic regions based on the location of their residence, and DSDS maintains an office in each region. The DSDS has 112 employees in the regional offices who perform assessments and reassessments and 18 employees in the regions who review reassessments performed by provider agencies. The DSDS uses an electronic case management system, and authorized units recorded on the system are transferred to the electronic payment system used by the DSS.

The MO Healthnet Division (MHD), a division within the DSS, processes and pays Medicaid claims submitted by HCBS providers and vendors. The payments are made from appropriations to the DHSS.

The MMAC unit, a unit within the DSS, contracts with provider agencies and vendors and investigates instances of noncompliance by providers or vendors with Medicaid policies, procedures, or regulations.

The Family Services Division within the DSS determines Medicaid eligibility of HCBS participants.

Provider agencies are responsible for delivering authorized IHS and ADC to participants. Much of the IHS are performed by an aide overseen by a registered nurse. About 500 providers are currently enrolled to provide IHS. Provider agencies delivered about 81 percent of total PC services authorized during December 2016.

Vendors and aides hired by the participant are responsible for delivering authorized CD services to participants. The aide delivers the services and

processes the billings through the vendor. About 722 vendors are enrolled to facilitate the delivery of CD services. During December 2016, about 90 percent of total authorized CD services were delivered.

Providers or vendors of IHS, CD services, and ADC services may only bill for services on the participant's authorized care plan.

Scope and Methodology

The scope of our audit included, but was not necessarily limited to, HCBS administered by the DSDS[3] during the four years ended June 30, 2017 and the 6 months ended December 31, 2017.

We obtained and analyzed data from the DHSS system containing participant assessments, LOC scores, and authorized services.

We obtained and analyzed data from the MHD system containing payments for HCBS services delivered in December 2017, 2016, and 2015. We used the data to compare units paid to units authorized and for other analyses.

For a sample of 25 participants assessed at the lowest eligible LOC score (21) in fiscal year 2017, we reviewed the assessment forms, care plans, and case notes for fiscal year 2017 and fiscal year 2018 assessments and or reassessments.

For 24 participants with relatively high or relatively low units of current authorized CD services and the same assessed needs level (LOC score 30), we compared the assessment forms, care plans, and case notes.

We reviewed budgets, budget estimates, appropriations, and DHSS correspondence and projections related to cost saving measures for fiscal year 2018.

We analyzed total annual HCBS expenditures using records of the state's accounting system (SAM II).

We analyzed trends in expenditures and participants.

We reviewed the DHSS HCBS manual and provider memos.

We reviewed the standard assessment form and accompanying manual.

[3] Other HCBS are administered by the DHSS Division of Community and Public Health. Those services include the Healthy Children and Families, AIDS waiver, and Medically Fragile Adults Waiver programs. Expenditures for those programs totaled about $80 million during fiscal year 2018.

Our methodology also included reviewing written policies and procedures, and interviewing various DSS and DHSS personnel. We obtained an understanding of the applicable controls that are significant within the context of the audit objective and assessed whether such controls have been properly designed and placed in operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violation of contract or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

1. Trends in Expenditures and Assessments and Reassessments

Average annual costs per participant have increased every year from fiscal year 2014 to 2017 as expenditure growth has outpaced caseload growth. Increases in the provider reimbursement rates and number of units of service authorized has driven much of the expenditure growth. The increases in authorized units has occurred despite relatively constant average level of care (LOC) scores. The Department of Health and Senior Services (DHSS), Governor's Office, and General Assembly made changes in fiscal year 2018 to slow the growth of the program costs by reducing reimbursement rates, number of participants, and amounts of allowable authorized units of consumer directed (CD) services. The numbers of assessments and reassessments performed annually has increased, and providers are performing an increasing share of reassessments.

Expenditures

The annual average rate of growth in total expenditures (11 percent) has outpaced the growth in participants (3 percent) leading to an increasing average annual cost per participant. Total annual expenditures to home and community based services (HCBS) providers and vendors, unduplicated HCBS participants receiving services during the year, and the average annual HCBS cost per participant for fiscal years 2014 through 2017 are presented in Table 3.

Table 3: Total expenditures, unduplicated participants, and average annual cost per participant, fiscal years 2014 through 2017

Fiscal Year	Total expenditures	Unduplicated participants	Average annual cost per participant
2014	$ 620,167,843	61,101	$ 10,150
2015	675,873,729	61,697	10,955
2016	725,061,720	65,290	11,105
2017	816,114,889	66,332	12,203

Source: Prepared by the SAO from SAM II expenditures and DHSS budget documents

Total expenditures for fiscal year 2018 ($805 million) were lower than fiscal year 2017 due to cost saving measures.[4] The growth in expenditures has been driven by the increase in the number of participants and an increase in the average cost per participant. According to DHSS officials, the growth in participants is primarily related to an aging population. The average cost per participant has increased as the state has increased the reimbursement rate for popular services, and the average number of units authorized for those services has also increased. For example for participants authorized CD or personal care (PC) services, the average number of monthly units authorized has increased in recent years (average annual increases of 6 percent and 9 percent for CD and PC service, respectively), and the reimbursement rate for

[4] Cost savings measures are discussed in more detail in MAR finding number 2. The number of participants for fiscal year 2018 was not available as of July 3, 2018.

those services has also increased (average annual increases of 3 percent) as noted in Table 4.

Table 4: Average monthly units authorized and unit reimbursement rates, CD and PC services, fiscal years 2014 through 2017

	Unit reimbursement rate		Average monthly units authorized	
Fiscal Year	CD	PC	CD	PC
2014	$ 3.69	$ 4.24	335	171
2015	3.89	4.47	355	199
2016	3.93	4.51	381	214
2017	4.01	4.60	395	219

Source: SAO analysis of DHSS participant database

Additionally, the average annual Medicaid cost per nursing facility (NF) resident trended upward during the period as noted in Table 5.

Table 5: Average annual Medicaid cost per nursing facility resident, fiscal years 2014 through 2017

Fiscal Year	Average annual Medicaid cost per nursing facility resident
2014	$ 36,132
2015	37,584
2016	38,160
2017	38,088

Source: DHSS budget requests

Although average HCBS costs have increased as noted in Table 3, those costs continue to remain much below average nursing facility costs.

LOC score and authorized services

Overall units of services authorized for a year generally tend to increase with increases in LOC score. For example, for CD services authorized in fiscal year 2016, average monthly authorized services increased as the LOC score increased as follows:

Table 6: CD services participants and average monthly units authorized, by LOC score for fiscal year 2016

LOC score	Number of participants	Average units of service authorized
21	4,588	302
24	4,430	328
27	4,382	351
30	4,346	369
33	4,267	388
36	3,528	413
39	2,808	431
42 and higher	4,406	496

Source: SAO analysis of DHSS participant database

However, when making comparisons from year-to-year of average authorized services and average LOC score, units and LOC score do not always trend directly. For example, the average LOC score for participants receiving PC or CD services stayed relatively constant during the period from fiscal year 2014 through fiscal year 2017 as noted in Table 7, but average units of service authorized increased throughout that period as noted in Table 4.

Table 7: Average LOC scores for PC and CD participants, fiscal years 2014 through 2017

Fiscal Year	Average LOC score for PC participants	Average LOC score for CD participants
2014	32	31
2015	32	31
2016	32	31
2017	32	32

Source: SAO analysis of DHSS participant database

Other variances between units of service and LOC score are noted in MAR finding number 3.

Fiscal year 2018 cost reductions

The DHSS, Governor's Office, and General Assembly made changes beginning in fiscal year 2018 to reduce the rate of growth of expenditures for budgetary reasons. As part of developing the appropriations for HCBS for fiscal year 2018, they decided to increase the LOC eligibility threshold, reduce the cap in allowable CD services, and reduce the provider reimbursement rates.

The LOC eligibility threshold was increased from 21 to 24. This change was expected to reduce the number of projected future participants in the HCBS program as noted in MAR finding number 2. The LOC threshold was last changed in fiscal year 2006 when it was increased from 18 to 21. Additionally, the cap on allowable CD service units was reduced for the first time from 100 percent to 60 percent of average annual Medicaid expenditures per NF resident (changed from 791 to 511 units per month). This change was expected to require reductions in the amount of authorized services for about 8,800 current participants. The reduction made the CD maximum comparable to the PC maximum, which had been at 60 percent of average NF resident costs for many years. Also, provider reimbursement rates were decreased by 3 percent. Provider reimbursement rates had generally increased each year in recent years. The changes seem to have been responsible for decreased expenditures in fiscal year 2018. Expenditures for fiscal year 2018 totaled approximately $805 million, about $11 million less than fiscal year 2017 expenditures, but more than $100 million less than projected costs if no benefit reductions had been made.

Assessments and reassessments

The total number of assessments and reassessments has increased in recent years due to the growth in the number of participants and the elimination of

the backlog of unperformed reassessments. Additionally, the number of reassessments performed by providers has especially increased in recent years. Assessments and reassessments completed during fiscal years 2014 through 2017 are noted in Table 8.

Table 8: Numbers of assessments and reassessments completed, fiscal years 2014 through 2017

	Fiscal Year			
	2014	2015	2016	2017
Initial assessments	18,228	19,137	18,563	18,418
Reassessments:				
DHSS	21,842	27,255	30,359	26,608
Providers	11,936	19,840	26,603	32,503
Total	52,006	66,232	75,525	77,529

Note: Total assessments often exceed the count of unduplicated participants in Table 3 because some participants receive more than 1 assessment per year, and some assessments result in no services as the potential participants were assessed at an LOC below the eligibility threshold.

Source: SAO analysis of DHSS participant database

Conclusion

Growth in expenditures and caseload and the increasing utilization of contracted providers to perform reassessments tends to generally create additional challenges in monitoring and controlling the HCBS program. While measures to reduce expenditure may help reduce growth to more manageable levels, such restrictions may also tend to make it more difficult to achieve program objectives due to reductions in service amounts and/or participation levels. Additionally, indirect relationships between average units authorized and average LOC scores further complicates efforts to manage and control the program. As noted in the following findings, improvements could be made to manage and control the HCBS program.

2. Budgetary Estimates

DHSS budgetary estimates of proposed program eligibility changes were not reasonable and resulted in overestimated cost savings projections for the LOC threshold change. DHSS estimated cost savings for fiscal year 2018 of about $43 million due to increasing the LOC threshold score from 21 to 24. However, the assumptions used to estimate the savings were not reasonable. The estimation was overstated because it assumed all 8,000 participants at the LOC 21 level would remain at that level (or lower) upon the next reassessment. DHSS data indicates historically many LOC 21 participants receive higher LOC scores when next reassessed. As noted in Table 9, the rates of LOC 21 participants receiving higher LOC scores at their next reassessment were about 18 percent, 29 percent, and 36 percent, for participants reassessed during fiscal years 2014, 2015, and 2016, respectively. Had DHSS officials considered these past results, their projected cost savings would have been significantly lower.

For example, using the 36 percent rate from fiscal year 2016 (the most recently completed fiscal year when DHSS fiscal year 2018 estimates were developed in January 2017), the estimated savings for the LOC threshold change would total about $28 million, or about $15 million lower than estimated by the DHSS. Additionally, as noted in MAR finding number 3, the rate of increased LOC scores for LOC 21 participants during fiscal year 2018 significantly exceeded the historical rates.

Underestimated program expenditures can lead to the need for supplemental appropriations. As a result, funding may have to shift from other priorities and not be available for those purposes. To improve the integrity of the budget process, it is essential the DHSS develop reasonable estimates of expected HCBS expenditures.

Recommendation

The DHSS develop more accurate budget estimates for HCBS services. When making program changes to produce costs savings, expenditure projections should consider any applicable historical rates.

Auditee's Response

The DHSS provided a written response. See Appendix A.

3. Level of Care Scores and Authorized Services

The DHSS lacks an effective system to identify individuals most in need of services for eligibility purposes and to score the severity of need among participants when determining the appropriate amount of services authorized. As a result, when the recent eligibility threshold increased from a LOC score of 21 to 24, unusually large numbers of participants with scores of 21 received new scores at or above the new threshold. Additionally, our review of 25 of those cases determined the new LOC scores and amount of authorized units were often not directly related. Similarly, the DHSS has significant long-standing differences in authorized units for participants assessed at the same LOC score among the state's regions that have not been sufficiently evaluated and addressed. The DHSS has begun efforts to improve the processes for assessments and reassessments of needs and development of plans of care to achieve better eligibility determinations and more uniformity and consistency in authorized services.

Implementation of the LOC threshold increase

Reassessments in fiscal year 2018 of participants with LOC scores of 21 from fiscal year 2017 resulted in disproportionately larger numbers of increased LOC scores compared to historical averages. Of the 5,497 reassessments completed July 2017 through May 7, 2018, of participants with LOC scores of 21, 4,081, or 74 percent, received higher LOC scores and remained eligible for services. In the previous 4 years when the LOC threshold was not changed, the percentage of participants with scores of 21 subsequently reassessed at higher scores were much lower, averaging about 30 percent per year. See Table 9.

Table 9: Reassessment results for participants with LOC scores of 21, fiscal years 2014 through 2018

	Fiscal Year				
	2014	2015	2016	2017	2018[1]
Number of participants with LOC score of 21 at beginning of fiscal year	11,880	10,597	9,521	7,978	5,497
Number of those participants subsequently reassessed at a higher LOC:					
- number	2,099	3,069	3,391	3,291	4,081
- percentage	18%	29%	36%	41%	74%

[1] Only includes reassessments from July 1, 2017 to May 7, 2018.

Source: DHSS analysis

The unusually large percentage of reassessments in fiscal year 2018 resulting in higher LOC scores creates questions as to whether some participants were improperly found to remain eligible for services under the higher LOC threshold. The unexpected results occurred despite refresher training provided by the DHSS personnel to department assessors in spring 2017 prior to implementation of the new threshold. No refresher training was given to provider reassessors.

The LOC score does not effectively reflect some circumstances affecting the need for HCBS of participants and potential participants and consequently has weaknesses as a tool to determine those most in need of services. Additionally, those weaknesses in the LOC score limits the ability of DHSS to compare needs assessments and authorized services and understand causes for unusual changes. For the 25 cases sampled of participants assessed at LOC 21 in fiscal year 2017 and reassessed at a higher LOC score in fiscal year 2018, many of the new LOC scores differ from previous LOC scores, but the authorized units of service did not correlate with the score change as noted below.

- For the 16 cases containing one or more assessments prior to the fiscal year 2017 assessment, 9 cases had assessment scores of 21 in all previous annual assessments.

- In 9 cases, the types and units of services authorized in fiscal year 2018 were the same as those in fiscal year 2017, and the number of units authorized either decreased or remained unchanged despite the increased LOC score (excluding those cases where the units authorized for fiscal year 2018 were lowered from the previous year to comply with the reduced maximum for CD services).

- For 6 cases, the participants received higher LOC scores in fiscal year 2018, but were authorized fewer units of service than in the previous year

to comply with the lowered maximum on CD services. These participants had been authorized many units of service for fiscal year 2017, despite being assessed at the lowest possible LOC score to receive services. The fiscal year 2018 LOC scores on these cases ranged from 24 to 45.

DHSS officials indicated the LOC score cannot always be related to units of service authorized because some issues affecting need are not proportionately reflected in the LOC score. For example, a participant receiving continuous oxygen typically receives the maximum LOC score of 9 in the treatment category, but participants with that disability may sometimes require relatively little HCBS; and the lack of support from spouse or family will not affect the LOC score, but a participant with few social supports often will receive relatively high units of authorized services.

Regional disparities in authorized services

The DHSS has not taken sufficient actions to evaluate and address inconsistencies in the average amounts of unit of service authorized among the regions. Significant differences exist between the regions, and the St. Louis region leads all regions in the amount of services authorized. For example, the average units of CD services per participant during fiscal year 2016 authorized in region 3 (St. Louis area), 457 units, exceeded all other regions and was about 61 percent more than the lowest-average region (2), 283 units, while average LOC scores among the regions was less variable, as noted in Table 10.

Table 10: Average CD services units and LOC score per participant by region, Fiscal Year 2016

Region	Geographic area	Average authorized units of CD services per participant	Average LOC score	Average units per LOC score
1	Southwest MO including Springfield	304	32	9.5
2	Southeast MO	283	29	9.8
3	St. Louis area	457	31	14.7
4	Northwest MO including Kansas City	427	33	12.9
5	Northeast MO and central MO	303	32	9.5

Source: SAO analysis of DHSS participant database

In previous audits,[5] we also noted participants were generally authorized more units of service in the St. Louis region than other regions. According to DHSS officials, transportation needs and social supports typically have little effect on LOC scores but these variables affect the amounts of services authorized, and participants in the St. Louis region often are authorized more units of service due to those participants typically having relatively few social

[5] SAO, Report No. 2006-69, *Health and Senior Services Home and Community-Based Services*, issued in November 2006, and SAO, Report No. 2004-02, *Medicaid Personal Care Services Program*, issued in January 2004.

supports and generally more access to medical care facilities than participants in other regions.

Based on our review and comparison of case documentation for 24 participants with LOC scores of 30 and relatively high or relatively low numbers of authorized CD services units, after considering social supports, units of service authorized still varied widely among the cases. For the tested cases, the number of authorized monthly units ranged from 186 to 511. Some of the high-authorized unit cases also had hours of informal care and active monitoring from family, friends, and/or neighbors within the last 3 days recorded on the assessment form, and some of the low-authorized unit cases had no hours of informal social support noted on the form. After considering the social supports (projecting the hours of social supports noted on the assessment form to a number of 15 minute monthly units and combining with the authorized DHSS services), the hours of total monthly support ranged from 226 to 871 for the tested cases. Most of the high units cases reviewed were from regions 3 and 4.

Recent efforts by DHSS

DHSS has recently taken actions, and is considering further actions, to improve the system and process for assessments and reassessments and service authorizations.

- In January 2018, the DHSS received a grant to contract with a consultant to study systems used by other states to provide recommendations to DHSS about improved practices for LOC assessments and reassessments and eligibility determinations. Results and recommendations from the consultant are expected in October 2018 with a decision about changes based on that information expected in November 2018.

- In October 2017, DHSS provided additional training to employees in the St. Louis regional office who tended to authorize relatively large amounts of services to help those employees authorize services more comparable to those of other assessors and reassessors.

- In February 2018, the DHSS developed a new form requiring the assessor or reassessor and participant to sign with attestations about the accuracy and truthfulness of the information in the assessment document.

- In fall 2017, the DHSS began requiring DHSS staff reviewing reassessments completed by providers to contact primary care physicians of the participant to verify information on the assessment form and help understand the causes for increases in LOC scores from the previous assessment or reassessment when they have questions about the reasons for increases in the LOC score for participants with previous LOC scores of 21.

- DHSS officials indicated they are considering purchasing additional decision support tools to assist in the development of individual participant care plans.

Conclusions

An effective system for measuring the needs of participants is necessary to ensure the most needy participants are provided appropriate services and the goals of the program are met. Without an effective system, unusual changes in participant LOC scores from year-to-year, units of service authorized that trend opposite to LOC scores, and disparities in units authorized among the regions for participants with the same LOC score can occur and create doubts about the accuracy of the assessment or reassessment and/or the propriety of the authorized services, and also make less predictable the results from changes to the LOC threshold. Developing a more effective LOC scoring system that better reflects participants needs along with establishing limits on the amounts of authorized services by LOC score in conjunction with other recent DHSS changes may help reduce such inconsistencies, disparities, and unusual results. A more consistent evaluation methodology will provide for more uniformity and fairness in services provided to participants.

Recommendation

The DHSS should continue efforts to improve the systems and processes for LOC assessments and authorizations of service, and consider establishing limits on the amounts of authorized services by LOC score.

Auditee's Response

The DHSS provided a written response. See Appendix A.

4. Provider Overpayments

Weaknesses in the DHSS and MHD systems prevent the proper execution of MHD system edits[6] to timely detect and prevent overpayments to some providers. Our review of MHD system records for December 2017, 2016, and 2015 indicated the number of monthly units of service billed by providers on behalf of participants and paid by the MHD often exceeded the total monthly number of units authorized by DHSS for those services and participants.

Based on a comparison of MHD system records of all HCBS units authorized and paid for December 2017, 2016, and 2015, we noted about 2,500 records totaling about $431,000 where units paid exceeded units authorized. For 17 of the records with relatively large units paid in excess of units authorized, we reviewed the authorizations on the DHSS system and noted 13 of the records seem to represent overpayments, or instances where services were billed and paid in excess of services authorized, totaling about $17,000. The discrepancies occurred during months when recipient care plans were reauthorized by DHSS due to reassessment or other reasons, and the MHD

[6] An edit, also known as a data validity check, is program code that tests the input for correct and reasonable conditions; such as account numbers falling within a range; numeric data being all digits; dates having a valid day, month, and year; etc.

system recorded the full amount of monthly authorized units for the participant under both the old and new care plans based on authorization data received from the DHSS system.

According to MHD and MMAC officials, the transfer of units authorization data between the DHSS and MHD systems is insufficient to allow for a pro-ration of the authorized units under each care plan (old and new) during months when a participant's care plan is changed causing MHD system edits to function improperly during those months, and MMAC audits of providers have also noted instances where providers billed and were paid for more units than authorized in those circumstances resulting in overpayments to be recouped because the MHD system did not detect those overpayments.

Without accurate information about service authorizations, edits denying, or flagging for further review, instances where billed units exceed authorized units are ineffective. Allowing a known weakness to continue to result in overpayments results in resources being unnecessarily used to identify the overpayments and seek collection.

In a previous audit of the MHD system,[7] we noted other edits did not function properly resulting in improper payments.

Recommendation

The DHSS and MHD implement changes to provide for more effective execution of MHD system edits to prevent and detect potential overpayments of HCBS benefits. In addition, the MMAC should investigate the potential overpayments identified and recoup any resulting overpayments.

Auditee's Response

The DHSS provided a written response. See Appendix A.

The DSS provided a written response. See Appendix B

[7] SAO, Report No. 2013-020, S*ocial Services Medicaid Management Information System Data Security*, issued in March 2013.

Appendix A
Home and Community Based Services
Auditee Response - Department of Health and Senior Services

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired and Voice dial: 711

Randall W. Williams, MD, FACOG
Director

Michael L. Parson
Governor

August 27, 2018

The Honorable Nicole Galloway, CPA
State Auditor
State Capitol, Room 121
Jefferson City, MO 65101

Dear Auditor Galloway,

The Department of Health and Senior Services (DHSS) is in receipt of the audit entitled Home and Community Based Services (HCBS) and has reviewed the draft audit report. This letter will serve as a written response to the audit recommendations 2.1, 3.1, and 4.1.

Recommendation 2.1: *The DHSS develop more accurate budget estimates for HCBS services. When making program changes to produce costs savings, expenditure projections should consider any applicable historical rates.*

While DHSS agrees with the aspect of this recommendation regarding program changes and the need to consider any applicable historical rates, the recommendation to develop more accurate budget estimates for HCBS services does not take into account all of the relevant projections provided to the Office of Administration-Budget & Planning, as well as the General Assembly, which historically have been reflective of actual expenditures. This recommendation is based on one estimate prepared for a specific purpose and assumptions. Given the size and variabilities of the program, DHSS will work to provide the most accurate budget estimates possible by studying all available information in formulating budget estimates. In addition, DHSS will continue to provide a detailed explanation of all assumptions used in formulating budget projections.

Recommendation 3.1: *The DHSS should continue efforts to improve the systems and processes for LOC assessments and authorizations of service, and consider establishing limits on the amounts of authorized services by LOC score.*

Response: DHSS will continue to move forward with changes to the nursing facility LOC. As DHSS has indicated, nursing facility LOC is one component of eligibility and not completely reflective of a participant's acuity level. Authorization of services in the current LOC process is person centered and based upon the needs of each individual participant, taking into account available formal and informal supports as well as the nursing facility LOC. DHSS will continue to move forward with analysis of different authorization systems, which would facilitate consistent person centered care planning amongst all regions, and provide targeted care planning guidance to the regions with higher authorization levels.

Recommendation 4.1: *The DHSS and MHD implement changes to provide for more effective execution of MHD system edits to prevent and detect potential overpayments of HCBS benefits. In addition, the MMAC should investigate the potential overpayments identified and recoup any resulting overpayments.*

Response: DHSS agrees with the recommendation. DHSS will evaluate system changes in the current prior authorization system. In addition, DHSS will provide further guidance to providers concerning this issue. DHSS will continue to work side-by-side with MHD and MMAC to identify potential solutions.

Thank you for your consideration.

Sincerely,

Randall W. Williams, MD, FACOG
Director

c: Jessica Bax, Director, Division of Senior and Disability Services
Tonya R. Loucks, Director, Division of Administration

Appendix B
Home and Community Based Services
Auditee Response - Department of Social Services

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

MICHAEL L. PARSON, GOVERNOR • STEVE CORSI, Psy.D., DIRECTOR

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WWW.DSS.MO.GOV • 573-751-4815 • 573-751-3203 FAX

October 11, 2018

Honorable Nicole R. Galloway, CPA
Missouri State Auditor
P.O. Box 869
Jefferson City, MO 65102

Dear State Auditor Galloway:

Please find below the Department of Social Services (DSS), MO HealthNet Division (MHD) and Missouri Medicaid Audit and Compliance (MMAC) combined response to the recommendation from the audit of the administration of the home and community based services (HCBS) program.

Audit Recommendation:

The DHSS and MHD implement changes to provide for more effective execution of MHD system edits to prevent and detect potential overpayments of HCBS benefits. In addition, the MMAC should investigate the potential overpayments identified and recoup any resulting overpayments.

DSS/MHD and MMAC Response:

MHD agrees, in part, with the findings of this report. MHD agrees that overpayments did occur in months where care plans were reauthorized by Department of Health and Senior Services (DHSS). MHD does not agree that these overpayments were due to the lack of system edits in the MHD system (MMIS). The appropriate edits exist in the MMIS to reimburse services in accordance with the authorization received from the DHSS system. MHD agrees with the recommendation to implement changes (in the authorization process) to provide for more effective execution of MHD system edits; however, this is subject to available state funding and staff resources.

In response to the recommendation to recoup overpayments, MMAC is running reports to identify each category of HCBS services that is authorized through DHSS within the MMIS system. MMAC opened a special project covering State Fiscal Years 2016, 2017, and 2018 and identified overpayments to providers

for Personal Care, Advanced Personal Care Assistance (PCA), and Consumer Directed Services (CDS) PCA Services; some of which was identified in the SAO report. MMAC is in the process of notifying the providers and recouping the identified overpayments. MMAC calculated the overpayments based on the number of units billed in excess of the larger amount of units authorized on the two Prior Authorizations. Additionally, MMAC is running separate reports for Respite, Home Maker Chore, Nursing, and Adult Day Care services.

Thank you for allowing the Department of Social Services, MO HealthNet Division and Missouri Medicaid Audit and Compliance the opportunity to prepare and submit this response.

Sincerely,

/s/

Steve Corsi, Psy. D
Director