Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Choices for Care

Improved Controls and Processes Could Reduce Risk of Improper Payments and Suspicious Transactions

July 27, 2018 Rpt. No. 18-05

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Mission Statement

The mission of the Auditor's Office is to hold state government accountable.

This means ensuring that taxpayer funds are used effectively and efficiently, and that we foster the prevention of waste, fraud, and abuse.

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Dear Colleagues,

Vermont offers home-based services to individuals eligible for Choices for Care (CFC), a Medicaid long-term services and support program managed by the Department of Disabilities, Aging and Independent Living (DAIL). DAIL offers CFC recipients a consumer or surrogate-directed services option that provides personal care, companion, and respite services to individuals at home, delivered by attendants chosen by and employed by the recipient or their surrogate, and paid from program funds through a payroll provider (ARIS Solutions, Inc.). ARIS, in turn, receives reimbursement from the Medicaid claims system, which is operated by DXC Technology under contract to the Department of Vermont Health Access (DVHA).

Nationally and in Vermont, the use of home-based care has given rise to compliance and fraud issues. For example, Vermont's Medicaid Fraud and Residential Abuse Unit (MFRAU) has obtained fraud convictions of attendants and/or their employers.

As a result of such abuses, our objective was to determine whether improper payments were made under Vermont's Medicaid CFC program's consumer or surrogate-directed home-based services option. We used data analysis techniques to compare authorization, timesheet, payroll, and claims records from multiple systems, looking both for improper payments resulting from transactions that broke specific rules (such as payment for services delivered at a time when the recipient was in hospital) and for transactions that reflected suspicious patterns (such as attendants paid to work improbable hours). We did not confirm the accuracy of timesheets or ARIS's data entry into their systems.

We identified about $150,000 in improper payments (most of our tests were for a 15-month period). For example, ARIS was reimbursed $48,000 for payments made on behalf of consumers who were not authorized to receive personal care services or had exceeded their budgets for this service. We also identified suspicious transactions. For example, 58 attendants were paid for 24 hours of care in a single calendar day 300 times; these included five instances of an attendant being paid for purportedly working all 168 hours in a week. We passed these results to MFRAU, which has opened several cases based on our analyses and plans to open other cases.

In researching the causes of these results, we found a reliance on manual processes, flawed or absent system edits (computerized tests to detect inaccuracies in eligibility, reporting, and payment), and insufficient monitoring of transactions. For example, the State did not check whether individual consumers over- or under-utilized their authorized service levels or perform audits or investigations of claims under the CFC consumer or surrogate-directed services option.

We made a variety of recommendations to DAIL and DVHA intended to correct the causes of our results. In addition, within the next couple of years, the Federal

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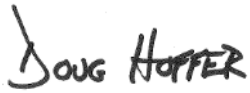
government is requiring Vermont and the other states to implement an electronic visit verification system, which is intended to verify that services billed for home and community-based personal or home health care are for actual visits made. Taken together, we believe that these changes provide an opportunity for the State to improve controls and processes over consumer or surrogate-directed services transactions.

I would like to thank the management and staff at DAIL, DVHA, ARIS, and DXC for their cooperation and professionalism throughout the course of this audit. This report is available on the state auditor's website, http://auditor.vermont.gov/.

Sincerely,



DOUGLAS R. HOFFER
State Auditor

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Introduction

Nationally, federal auditors have found significant and persistent compliance, payment, and fraud vulnerabilities related to Medicaid payments for personal care services (PCS), which are nonmedical services furnished to vulnerable care-dependent persons.[1] Such vulnerabilities have also been found in Vermont as the Office of the Vermont Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU) has obtained fraud convictions of PCS attendants and/or their employers.[2] Examples of improper payments related to PCS activities are services that were not provided in compliance with requirements and billing for services not rendered.

Vermont offers PCS and other home-based services to individuals eligible for Choices for Care (CFC),[3] a Medicaid program managed by the Department of Disabilities, Aging and Independent Living (DAIL). Among other options, CFC provides eligible individuals who want to live in a home-based setting with access to a case manager to help coordinate a plan for services. Care may be provided through a designated home health agency or through the consumer or surrogate-directed option. Under the latter option, the consumer (the CFC recipient, also known as a participant) or designated surrogate is the employer of attendant(s) that provide PCS, companion, and/or respite services.[4] DAIL contracts with ARIS Solutions, Inc. to provide these employers with payroll services, such as timesheet and paycheck processing. ARIS is reimbursed for CFC payroll transactions by the Medicaid claims processing system.

Because of the risk of inappropriate claims for home-based care, we performed an audit with an objective to determine whether improper payments were made under Vermont's Medicaid CFC program's consumer or surrogate-directed home-based services option. Our focus was evaluating and comparing data from applicable systems, not confirming the accuracy of timesheets or ARIS's data entry into their systems. Appendix I contains detail on our scope and methodology. Appendix II contains a list of abbreviations used in this report.

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1 *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (U.S. Department of Health and Human Services Office of Inspector General, rpt no. OIG-12-12-01, November 2012) and *Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services* (U.S. Department of Health and Human Services Office of Inspector General, October 3, 2016).

2 *Vermont Medicaid Fraud and Residential Abuse Unit 2017 Annual Report* (Office of the Vermont Attorney General).

3 PCS are also provided by other Vermont programs, such as the Department of Health's children's personal care services program.

4 Under CFC, PCS is defined as assistance with activities of daily living, like eating and bathing, and instrumental activities of daily living such as cooking and cleaning. Companion care is nonmedical supervision and socialization for participants who are not able to care for themselves. Respite care provides alternative care giving arrangements to facilitate short-term and time-limited breaks for unpaid caregivers.

Highlights

Vermont's Choices for Care (CFC) program allows eligible individuals to obtain services in a home-based setting in which consumers (CFC recipients) or surrogates employ attendants to provide personal care services (PCS), respite, and/or companion services. Because compliance, payment, and fraud vulnerabilities have been associated with the provision of home-based care, we conducted an audit to determine whether improper payments were made under Vermont's Medicaid CFC program's consumer or surrogate-directed home-based services option. Our focus was evaluating and comparing data from applicable systems, not confirming whether timesheets were accurate or correctly entered into the ARIS systems.

Objective 1 Finding

Our comparison of data from systems that support the CFC consumer or surrogate-directed home-based services option found improper payments and suspicious transactions. CFC consumer or surrogate-directed services are authorized and paid via a combination of organizations, processes, and systems. These include: (1) the Department of Disabilities, Aging and Independent Living (DAIL), which authorizes the level of PCS, companion, and respite care to be provided to consumers; (2) ARIS, which processes timesheets submitted by employers and pays attendants;[5] and (3) a contractor to the Department of Vermont Health Access (DVHA), which processes Medicaid claims and reimburses ARIS.

Table 1 summarizes our tests of a type of improper payment—those made in error or in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. These improper payments totaled about $150,000 (most of the tests were for a 15-month period). Between July 1, 2016 and September 30, 2017, ARIS was reimbursed $24 million for consumer or surrogate-directed services claims. During this 15-month period, ARIS paid 2,075 attendants on behalf of 1,213 consumers. Our analyses also identified suspicious transactions that may be an indicator of fraudulent activities (see Table 2). The results of these tests were not mutually exclusive as some attendants were identified in multiple tests. Determining whether these transactions were, in fact, fraudulent is beyond our professional responsibilities. Accordingly, we briefed officials from the Medicaid Fraud and Residential Abuse

[5] Attendants are responsible for preparing and signing correct timesheets, including the dates and times of services. Employers, in turn, are responsible for verifying that the services were received and signing and submitting the timesheets to ARIS.

Unit (MFRAU) on our results and provided them with electronic files containing the suspicious transactions. As of June 6, 2018, MFRAU had several open cases based on the analyses we provided. MFRAU was still in the process of reviewing the information and planned to open other cases in the near future.

Table 1: Summary of Results of Improper Payments Tests for CFC Consumer or Surrogate-Directed Services[a]

Test Objective	Results	Estimated Amount of Improper Payments[b]
Determine whether consumers received PCS for which they were not authorized.	ARIS was reimbursed for 21 claim lines[c] on behalf of 7 consumers who were not authorized to receive PCS on the dates of service.	~$8,000
Determine whether consumers received more PCS than what was authorized.	ARIS was reimbursed for 487 claim lines on behalf of 133 consumers for PCS that exceeded their authorized budgets. Most of the improper payments were for 14 consumers whose PCS budgets were exceeded by more than $1,000.	~$40,000
Determine whether consumers received more than 720 hours of companion and/or respite care without an authorized variance, which is the maximum allowed by CFC rules.	• ARIS was reimbursed for claims on behalf of 202 consumers for companion/respite care of more than 720 hours in 2016, even though there was no approved variance. • An additional 5 consumers had a variance, but ARIS was reimbursed for payments made in excess of the variance.	~$78,000
Determine whether attendants were paid for PCS, respite, or companion services on dates in which the consumer was in a facility (e.g., hospital or nursing home).	• ARIS was reimbursed for 100 claims for home-based services to 74 consumers during dates in which they were in a hospital. • ARIS was reimbursed for 5 claims for home-based services to 5 consumers during dates in which they were in a nursing home.	~$17,000 - $19,000
Identify instances of attendants claiming to have provided multiple services or served multiple recipients simultaneously.	On 64 occasions, ARIS paid attendants for shifts that overlapped. In some cases, the overlapping shifts involved providing services to the same CFC recipient while in others the overlap included services to different recipients that, in some cases, were enrolled in other programs.	~$2,000
Determine whether attendants were incorrectly paid overtime.	In 395 instances ARIS paid an attendant for more overtime than appeared justified by the total hours paid for the week (e.g., overtime was paid when payroll data indicated that the attendant did not exceed 40 hours in a week).	Up to $7,000[d]

[a] The service dates used in each test depended upon the system being used for the test. Most of our tests were performed for the 33 payroll periods that encompassed dates of services between July 1, 2016 to September 30, 2017. We also obtained Medicaid claims data for earlier dates of services in 2016 to perform a test that was based on a calendar year.

[b] These costs include the employers' share of payroll taxes and amounts for workers' compensation and unemployment insurance. The improper payments expressed as a range indicates that we could not definitively determine the amount of payments that ARIS made for certain records.

[c] A claim can be comprised of multiple detail lines that support the total amount claimed.

[d] We found examples of overtime hours paid inappropriately, but were unable to definitively determine the extent to which this occurred because of transactions in which there was a confluence of overtime hours and consumer budgets that were exceeded for a service.

Table 2: Summary of Selected Tests to Identify Suspicious CFC Consumer or Surrogate-Directed Services Transactions

Test Objective	Results
Determine whether any attendants were paid for providing 20 or more hours of care in a single calendar day.	98 attendants were paid for between 20 - 24 hours of care in a single calendar day a total of 666 times. In a subset of these figures, 58 attendants were paid for 24 hours of care in a single calendar day 300 times (none were paid to work more than 24 hours in a day).
Determine whether any attendants were paid for an unlikely number of hours in a given week.	43 attendants were paid for 100 or more hours in a given week a total of 185 times (the maximum number of hours in a week is 168). Three of these attendants were paid for 168 hours in a week on a total of 5 occasions.
Determine whether any attendants were paid to work an implausible number of days during the period under review (July 1, 2016 – September 30, 2017, or 457 calendar days).	• 47 attendants were paid to work every one of the 457 days under review. • 153 attendants were paid to work between 428 to 456 days during the period under review (less than 2 days off a month).
Determine whether there was a suspicious pattern of usage of authorized companion/respite hours.	46 consumers used 90 percent or more of their total hours for calendar year 2016 for respite or companion care in the first six months of that year.

These improper payments and suspicious transactions can be attributed to three causes: (1) reliance on manual processes, (2) flawed or absent system edits (computerized tests to detect inaccuracies in eligibility, reporting, and payment), and (3) insufficient monitoring of transactions. Regarding the latter cause, Federal regulations require the State to perform utilization reviews and program integrity activities. The State did not have effective mechanisms in place to comply with these regulations for the CFC consumer or surrogate-directed services option primarily because the multiple systems that authorize services, perform detailed timesheet and payroll transactions, and pay Medicaid claims were not integrated. Because of this lack of integration, the State did not check whether individual consumers over- or under-utilized their authorized service levels or perform audits or investigations of claims under the CFC consumer or surrogate-directed services option.

The State expects to improve controls over CFC consumer or surrogate-directed services via the implementation of a Federal law that requires an electronic visit verification (EVV) process to be in place for PCS within the next couple of years. EVV systems are intended to improve controls by providing a process to verify, for example, the location, date and time, and individual delivering the service. As of mid-June 2018, the State was in the process of determining how it will implement the EVV initiative. Without such detail, we cannot assess the extent to which EVV will address the causes of improper payments.

Recommendations

We made a variety of recommendations to DAIL and DVHA to recover identified improper payments as well as to correct flaws in their processes and systems that caused the improper payments and suspicious transactions.

Background

Medicaid is the largest funding source in the United States for long-term services and supports, which are generally provided in either institutional facilities, such as nursing homes, or community settings, such as individuals' homes. Vermont's Medicaid long-term services and support program is CFC. To be eligible for CFC, an individual must (1) be a Vermont resident aged 18 or older who meets both clinical and financial criteria, (2) have a functional physical limitation resulting from a physical condition[6] or associated with aging (e.g., stroke, dementia), and (3) have needs that cannot be met by services available from other sources (e.g., Medicare, private insurance).

Eligible individuals are placed in one of three CFC groups: (1) the highest needs group in which individuals are in need of nursing home level of care and are guaranteed services; (2) the high needs group in which individuals are in need of nursing home level of care but have slightly lighter clinical needs and may be placed on a waiting list; and (3) the moderate needs group in which individuals do not require nursing home level of care and may be placed on a waiting list.[7] Only individuals in the highest and high needs groups may participate in the CFC program's consumer or surrogate-directed services home-based option.

A key feature of the consumer or surrogate-directed services option is that the consumer or a surrogate serves as the employer of attendants, not the State. Among the responsibilities of the employer are developing a work schedule, hiring attendant(s), deciding the wage rate of the attendant (within a minimum[8] and maximum range), approving timesheets based on the approved plan and actual time worked, evaluating attendant(s) performance, and terminating attendant(s) when necessary. The types of services authorized by the CFC consumer or surrogate-directed services option and performed by attendants are PCS, companion, and respite care.

CFC consumer or surrogate-directed services are authorized and paid via a combination of organizations, processes, and systems as follows (see Figure 1 for an illustration of these relationships).

- *Agency of Human Services (AHS)/DAIL.* DAIL manages the CFC program. Its responsibilities include determining clinical eligibility and approving CFC consumers' care plans and changes to these plans. Approved CFC

6 Individuals whose need for services is due to developmental disabilities, autism, or mental illness are not eligible for the CFC program.

7 The high needs group has not had a waiting list since 2011. As of April 2018, hundreds of individuals were on the moderate needs group waiting list.

8 AHS has agreed to a minimum wage rate in a collective bargaining agreement with Vermont Homecare United, American Federation of State, County and Municipal Employees (AFSCME).

care plans and changes to these plans are contained in the Social Assistance Management Software (SAMS).

- *AHS/Department of Vermont Health Access (DVHA).* DVHA is responsible for determining the financial eligibility of CFC applicants and adding approved individuals into ACCESS—a system that records Medicaid eligibility. In addition, DVHA oversees the operations of DXC Technology (formerly Hewlett Packard Enterprise), the Medicaid fiscal agent, which performs claims processing. Claims are processed using the Medicaid Management Information System (MMIS).

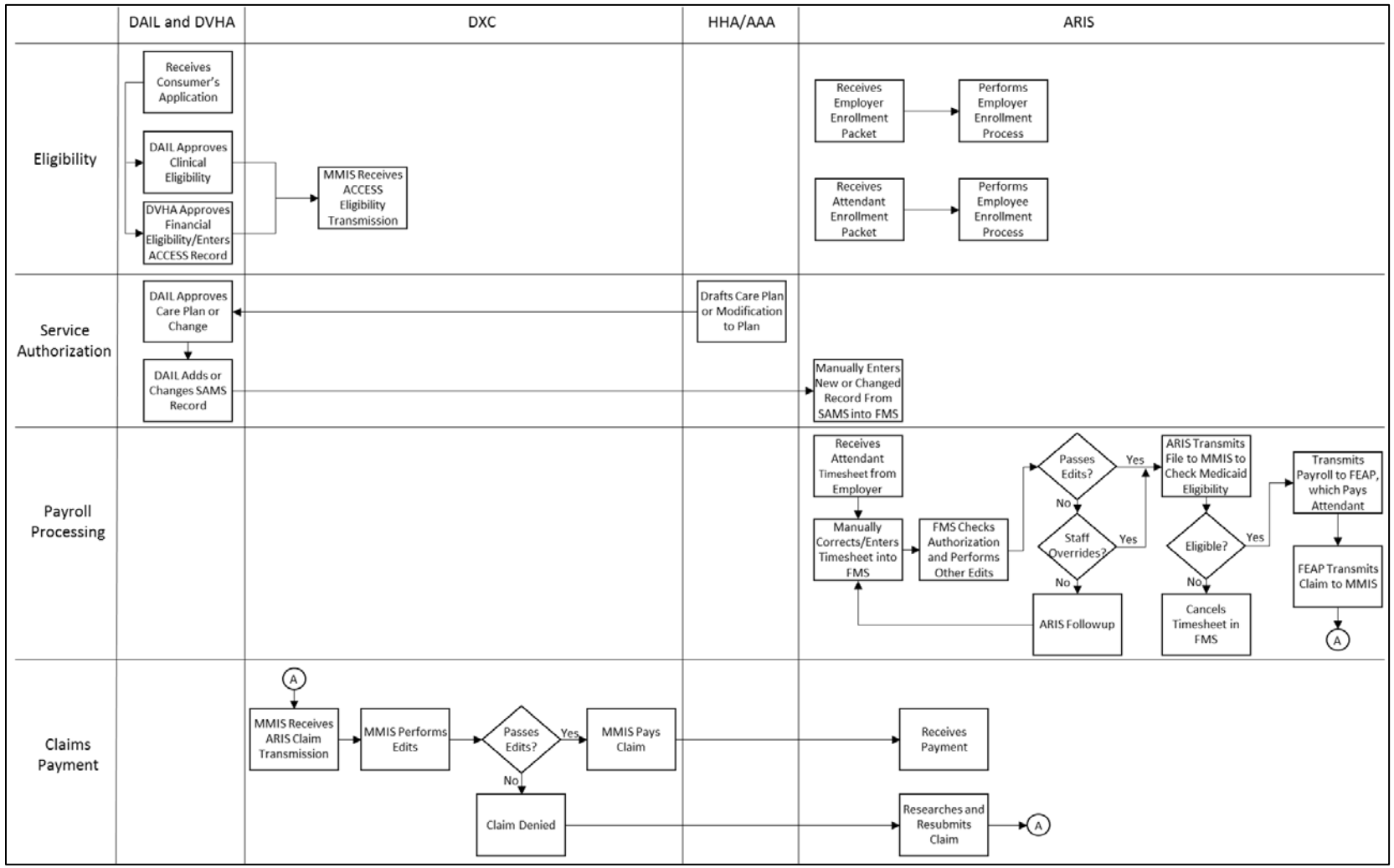
- *Home Health Agencies (HHA) and Area Agencies on Aging (AAA).* These organizations are responsible for providing case management services, which include developing care plans for individuals, certifying the ability of a consumer or surrogate employer to manage services, and monitoring the delivery of services to ensure they are being provided as planned. Monitoring is to include regular contact with the CFC recipient, caregivers, and service providers.

- *ARIS Solutions, Inc.* DAIL contracts with ARIS to act as the fiscal/employer agent for CFC consumer or surrogate-directed services as well as for other CFC and non-CFC programs.[9] ARIS performs a variety of tasks in this role, including (1) enrolling employers and attendants, (2) processing timesheets, (3) issuing paychecks to attendants, and (4) performing other payroll activities, such as paying employment-related taxes and workers' compensation insurance policy premiums. ARIS submits claims to the MMIS for reimbursement of the payroll that it processes on behalf of individual consumers (including wages and other employment-related costs).

  ARIS is also responsible for ensuring that payments to attendants are only made for authorized services for enrolled CFC consumers and for the correct amounts. ARIS utilizes manual and automated processes to accomplish these requirements. For example, ARIS utilizes a vendor's system (FMS Engine) to enroll consumers and attendants and process timesheets, including checking that submitted hours are authorized by DAIL. Paychecks are generated by an ARIS-developed system called Fiscal Employer/Agent Payroll (FEAP).

[9] An example of another CFC program is the flexible choices program. Examples of non-CFC programs that use ARIS services are the children's personal care services, traumatic brain injury, and developmental disabilities services programs.

Figure 1: High-Level Overview of the Organizations, Processes, and Systems Used to Authorize and Pay for CFC Consumer or Surrogate-Based Services



Objective 1: DAIL and DVHA Could Reduce Improper Payments and Suspicious Transactions with Improved Controls and Processes

Our comparison of data from several State and contractor systems found improper payments and suspicious transactions in claims under the CFC consumer or surrogate-directed option. These results can be attributed to process limitations and control weaknesses. In particular, a reliance on manual processes, flawed or missing system edits, and limited monitoring of consumer or surrogate-directed transactions by DAIL and DVHA. In response to a federal law, the State plans to implement an electronic visit verification (EVV) process that it expects will improve controls. The State is still working on how EVV will be implemented, so it is premature for us to evaluate whether, and to what extent, this initiative will improve controls over payments to attendants and address the causes of improper payments.

Improper Payments and Suspicious Transactions

Attendants are responsible for preparing and signing correct timesheets, including the dates and times of services. Employers, in turn, are responsible for verifying that the services were received and signing and submitting the timesheets to ARIS. Once ARIS processes the timesheets and pays the employees, it (1) provides the employer with a copy of a statement that includes the funds paid and the balance remaining in the authorized funding limits and (2) submits claims to the MMIS for reimbursement. ARIS was reimbursed $24 million for 25,911 consumer or surrogate-directed services claims for services provided between July 1, 2016 and September 30, 2017. During this 15-month period ARIS paid 2,075 attendants on behalf of 1,213 consumers.

We obtained data files from the systems that contain CFC care plans (SAMS), paid Medicaid claims for CFC recipients (MMIS), timesheets (FMS Engine) and payroll (FEAP) for consumer or surrogate-directed services.[10] We performed various analyses using these data files to identify (1) payments not in conformance with state requirements (improper payments) and (2)

[10] The service dates used in each test depended upon the system used in the test. Most of our tests were performed for the 33 payroll periods that encompassed dates of services between July 1, 2016 to September 30, 2017. We chose the beginning of this period because ARIS transitioned to the payroll system FMS Engine in April 2016. We also obtained MMIS data for earlier dates of services in 2016 to perform a test that was based on a calendar year.

suspicious transactions that could indicate fraudulent activity. These categories are not mutually exclusive, as an improper payment may have occurred due to fraud.

Table 3 summarizes the results of our tests of a type of improper payment—those made in error or in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.[11] These improper payments totaled about $150,000 for a 15-month period. The analysis with the largest amount of improper payments related to consumers who received more than 720 hours in companion/respite care without a variance that authorizes more services, which contravenes CFC rules. In our analysis of whether overtime was correctly paid, we found examples of overtime hours paid inappropriately. However, we were unable to definitively determine the extent to which this occurred because of transactions in which there was a confluence of overtime hours and consumer budgets that were exceeded for a service. For timesheets that exceed 40 hours in a given week, FMS Engine calculates a blended average of overtime hours and wages across service codes (e.g., PCS, respite care) for attendants that are not exempted from overtime.[12] FMS Engine validates the timesheet against the consumer's budget for each service that was provided. If the budget was exceeded for a service, ARIS only pays the attendant to the amount of the budget, unless DAIL authorizes additional funding. Our analysis of FEAP (ARIS's payroll system) data showed 395 transactions in which overtime was paid even though the total hours paid did not exceed 40 hours. We provided examples of these transactions to ARIS and they explained that some were in error while others occurred due to how they process overtime and budgets. We could not determine which explanation applied to each of these transactions based on the data in FMS Engine and FEAP that we received. Because of the complicated nature of the ARIS process, it appears to warrant a State review to determine that payroll involving overtime is being properly calculated.

[11] Per the Centers for Medicare and Medicaid Services, other types of improper payments include payments on behalf of ineligible beneficiaries, payments without supporting documentation or payments for good or services not received. These types of improper payments were outside of the scope of our audit.

[12] An attendant may be exempt from receiving overtime under the Fair Labor Standards Act (e.g., if the attendant resides with the employer). While FMS Engine initially calculates overtime for all attendants, ARIS staff remove the overtime line for those that are exempt.

Table 3: Summary of Results of Improper Payment Tests for CFC Consumer or Surrogate-Directed Services

Test Objective	Criteria	Results	Estimated Amount of Improper Payments[a]
Determine whether consumers received PCS for which they were not authorized. The service date range of claims tested was July 1, 2016 to September 30, 2017.	• PCS is limited to individuals approved by DAIL for services in a home-based setting. A provider shall not bill the State for CFC services until DAIL has authorized a CFC service plan. (CFC manual[b]) • ARIS shall review the types of services on timesheets to ensure that the consumer is eligible for the dates and services represented. (ARIS contract)	ARIS was reimbursed for 21 claim lines[c] on behalf of 7 CFC consumers who were not authorized to receive PCS on the dates of service.	~$8,000
Determine whether consumers received more PCS than what was authorized. The service date range of claims tested was July 1, 2016 to September 30, 2017.	• PCS is limited to the maximum hours allocated on the DAIL approved service plan. (CFC manual) • ARIS shall review the number of hours and types of services on timesheets to ensure that the amount paid does not exceed the authorized limits. (ARIS contract) In April 2016, DAIL changed from authorizing PCS services on an hourly basis to a bi-weekly budget that sets the maximum dollars that DAIL will authorize unless it grants a variance.	ARIS was reimbursed for 487 claim lines on behalf of 133 consumers for PCS that exceeded their authorized CFC budgets. Most of the improper payments were for 14 consumers whose PCS budgets were exceeded by more than $1,000.	~$40,000
Determine whether consumers received more than 720 hours of companion and/or respite care without an authorized variance. The service date range of claims tested was January 1, 2016 to December 31, 2016.	• Companion and respite care are limited to a total of 720 hours a calendar year combined unless DAIL grants a variance. (Code of Vermont Rules 13-110-008, amended February 9, 2009 and CFC manual) • ARIS shall review the number of hours and types of services on timesheets to ensure that the amount paid does not exceed the authorized limits. (ARIS contract)	• ARIS was reimbursed for claims on behalf of 202 CFC consumers for companion/respite care of more than 720 hours in 2016, even though there was no approved variance. • An additional 5 CFC consumers had a variance, but ARIS was reimbursed for payments made in excess of the approved variance.	~$78,000

Test Objective	Criteria	Results	Estimated Amount of Improper Payments[a]
Determine whether attendants were paid for PCS, respite, or companion services on dates in which the consumer was in a facility (e.g., hospital or nursing home). The service date range of claims tested was June 19, 2016 to September 30, 2017.	PCS shall not be furnished to individuals who are inpatients of a hospital or nursing facility. Respite and companion services are limited to home-based settings. (CFC manual) We excluded the start and end dates for consumers' facility stays in this analysis.	• ARIS was reimbursed for 100 claims for PCS, companion, or respite services to 74 CFC consumers purportedly performed on dates in which they were in a hospital. • ARIS was reimbursed for 5 claims for PCS, companion, or respite services to 5 CFC consumers purportedly performed on dates in which they were in a nursing home.	~$17,000 - $19,000
Identify instances of attendants claiming to have provided multiple services or served multiple recipients simultaneously. The service date range of claims tested was June 19, 2016 to October 7, 2017.	CFC services shall be provided in a cost-effective and efficient manner and prevent duplication of services and unnecessary costs. (CFC manual) According to the DAIL adult services division director, PCS should not be provided to two different recipients at the same time and a consumer can only receive one service at a time.	On 64 occasions, ARIS paid attendants for shifts that overlapped. In some cases, the overlapping shifts involved providing services to the same CFC recipient while in others the overlap included services to different recipients that, in some cases, were enrolled in other programs (e.g., the children's personal care services program). For example, ARIS paid an attendant for two simultaneous shifts of 10 hours to provide PCS to the same consumer.	~$2,000
Determine whether attendants were incorrectly paid overtime. The service date range of claims tested was June 19, 2016 to September 23, 2017.	Attendants should be paid time and a half for any time s/he works greater than 40 hours in a week unless the attendant (1) provides only companion care or (2) is a "live-in domestic service employee." (DAIL memo dated October 13, 2015)	In 395 instances ARIS paid an attendant for more overtime than appeared justified by the total hours paid for the week (e.g., overtime was paid when FEAP payroll data indicated that the attendant did not exceed 40 hours in a week).	Up to $7,000

[a] These estimates take into account the employer's share of payroll taxes and amounts for workers' compensation and unemployment insurance. The improper payments expressed as a range indicates that we could not definitively determine the amount of payments that ARIS made for certain transactions.

[b] *Choices for Care Vermont Long-Term Services & Supports Program Operations Manual Highest and High Needs Group* (DAIL, revised May 2015).

[c] A claim can be comprised of multiple detail lines that support the total amount claimed.

Overpayments may result in the loss of the federal share of improperly paid claims. Per 42 CFR §433, subpart F, the State has one year to recover or seek to recover overpayments from the date of discovery before having to report the overpayment to the Centers for Medicare and Medicaid Services (CMS) and return the federal share to CMS via a credit on the Quarterly Statement of

Expenditures.[13] DVHA is responsible for reporting overpayments to AHS central office, which submits the quarterly reports to CMS.

We performed other tests of data to identify improper payments, and none were found. For example, we found no improper payments made (1) on behalf of consumers after their dates of death, (2) to attendants for shifts after their dates of death, (3) on behalf of consumers who received services from more than one program in the same week, (4) to attendants who also served as surrogates to the same CFC attendant, and (5) to attendants for greater than the maximum hourly rate allowed by DAIL.

Our analyses also identified suspicious transactions that may be indications of fraudulent activities. These transactions resulted from improbable circumstances, which we identified through discussions with the MFRAU and our research. For example, according to the federal Department of Health and Human Services' Office of the Inspector General, PCS attendants and agencies that commit fraud often bill for impossibly or improbably large volumes of services.[14] Table 4 provides a summary of some of our tests for such suspicious transactions. The results of these tests were not mutually exclusive as some attendants were identified in multiple tests.

[13] The federal share is based on the Federal Medical Assistance Percentage, which in fiscal years 2016 and 2017 was 53.9 percent and 54.46 percent, respectively. In fiscal year 2016, Vermont also received enhanced Federal Medical Assistance Percentage for certain Medicaid enrollment populations, but not for CFC.

[14] *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (U.S. Department of Health and Human Services Office of Inspector General, rpt no. OIG-12-12-01, November 2012).

Table 4: Summary of Selected Tests to Identify Suspicious CFC Consumer or Surrogate-Directed Services Transactions

Test Objective	Results
Determine whether any attendants were paid for providing 20 or more hours of care in a single calendar day. The service date range of claims tested was June 19, 2016 to October 7, 2017.	98 attendants were paid for between 20 - 24 hours of care in a single calendar day a total of 666 times. In a subset of these figures, 58 attendants were paid for 24 hours of care in a single calendar day 300 times (none were paid to work more than 24 hours in a day).
Determine whether any attendants were paid for an unlikely number of hours in a given week. The service date range of claims tested was June 26, 2016 to September 30, 2017.	43 attendants were paid for 100 or more hours in a given week a total of 185 times. Three of these attendants were paid for 168 hours, or the maximum number of weekly hours (24 hours x 7 days), on a total of 5 occasions.
Determine whether any attendants were paid to work an implausible number of days between July 1, 2016 – September 30, 2017, or 457 calendar days.	• 47 attendants were paid to work every one of the 457 days under review. The average number of hours for which each of these attendants were paid to work each day ranged from 1 hour to 16.8 hours. • 153 attendants were paid to work between 428 to 456 days during the period under review (less than 2 days off a month).
Determine whether there was a suspicious pattern of usage of authorized companion/respite hours. The service date range of claims tested was January 1, 2016 to December 31, 2016.	46 consumers used 90 percent or more of their total hours for calendar year 2016 for respite or companion in the first six months of that year.

Whether any of these transactions were, in fact, fraudulent cannot be determined without an investigation because it must be established than an individual falsified a claim and that it was done intentionally to achieve some gain. This is a determination beyond our professional responsibilities and is properly in the realm of the judicial or other adjudicative system. Accordingly, we briefed MFRAU officials on our results in March 2018 and provided them with electronic files containing suspicious transactions for further investigation.[15] As of June 6, 2018, MFRAU had several open cases based on the analyses we provided. MFRAU was still in the process of reviewing the information and planned to open other cases in the near future.

Causes of Improper Payments and Suspicious Transactions

A variety of causes led to the specific improper payments and suspicious consumer or surrogate-directed services transactions identified during this

[15] We also briefed DAIL officials in detail on the results of our improper payment and suspicious transaction tests in April 2018.

audit, including (1) reliance on manual processes, (2) flawed or missing system edits, and (3) insufficient monitoring of transactions.

Reliance on Manual Processes

Manual processes are key features of the service authorization and payment activities performed for the consumer or surrogate-directed services option. In particular, ARIS relies on manual data entry for its timesheet processing. For example, while employers may submit timesheets electronically, ARIS staff manually enter data from the timesheets into FMS Engine. ARIS staff also download consumers' care plan data from SAMS and then manually enter it into FMS Engine. In addition, some FMS Engine edits can be overridden by ARIS clerks. The improper payments pertaining to payments for unauthorized services and overlapping shifts were largely attributed to ARIS staff mistakes.

Flawed or Absence of System Edits

Prevention is a more efficient and effective means to minimize fraud, waste, and abuse rather than trying to recover payments once they are made. One type of prevention method is the use of system edits. System edit checks are computerized tests to detect inaccuracies in eligibility, reporting, and payment. System edits to enforce certain CFC requirements were either flawed or absent.

- *Companion and Respite Care Restriction.* Under CFC rules, companion and respite care is limited to 720 hours in a calendar year unless DAIL approves a variance. FMS Engine lacks an edit to enforce this rule. Instead, ARIS checks whether the consumer has exceeded its companion and respite dollar budget. According to ARIS officials, an edit to check whether the 720-hour maximum is exceeded could be configured into the system, but they have not asked the FMS Engine vendor to do so. This lack of an FMS Engine edit is exacerbated by the edit in the Medicaid claims payment system (MMIS) that is set at the wrong maximum level of units.[16] ARIS submits companion and respite claims to the MMIS based on quarter-hour units, so the maximum number of these units permitted without a variance is 2,880. The MMIS edit that checks that the 720-hour maximum is not exceeded without a variance used this figure until October 2017.[17] At that time and at DAIL's request, DXC deployed a change to the MMIS that set the maximum to 5,760 units (1,440 hours)—double the amount allowed in the CFC rules. DAIL requested this change because in April 2016 it had shifted from authorizing hour-based units in

[16] This report uses the term "edit" in a general sense. The MMIS uses the term error status code to check the validity of Medicaid claims. Some of these codes are labeled as "audits," which is a comparison of each new claim to the beneficiary's claims history.

[17] Although the change was not made until October 2017, ARIS resubmitted 2016 claims that had previously been denied after this date, which were then paid by MMIS, as agreed upon with DAIL.

its consumer care plans to authorizing a dollar-based budget.[18] However, this change did not discontinue the 720-hour rule. In approving this system change, DVHA's program integrity unit stated that DAIL should ensure that monitoring take place after the implementation of the change to ensure that the outcome was as intended. However, as of March 13, 2018 DAIL had not implemented such a process. As a result, neither FMS Engine, MMIS, nor DAIL has effective controls in place to ensure that the CFC companion/respite 720-hour rule is enforced.

- *Prohibition on Home-Based Care When Consumer in Nursing Home.* CFC does not pay attendants to provide care while the consumer is in a nursing home. The MMIS edit that checks whether home-health claims are submitted for days in which a consumer is in a nursing facility contained flawed logic. This flaw was discovered after we brought our results to DXC's attention. DXC fixed the edit in January 2018 and later recouped $10,482 (DVHA was researching whether an additional $1,144 in claims needed to be recouped).[19]

- *Prohibition on Home-Based Care When Consumer in Hospital.* CFC does not pay attendants to provide care while the consumer is in a hospital. The MMIS does not have an edit that checks whether home-health claims are submitted for days in which a consumer is in a hospital. When asked why the MMIS did not have such an edit, a DXC system official replied that she would not know why a specific edit did not exist other than they had not been asked to develop one. The DAIL director of the adult services division did not know why such an edit did not exist. The lack of such an edit is of particular consequence because there is no effective preventive control at ARIS to stop the payment for time purported to have been worked on days in which the consumer is in a hospital. ARIS relies on the employer to indicate on the timesheet whether and on what days the consumer was in a hospital. However, employers did not always provide this information or submitted timesheets asserting that the consumer was not in the hospital. About 96 percent of the $17,000-$19,000 in improper payments made for attendants' services reported to have been provided while the consumer was in a facility was attributed to when the consumer was in a hospital.

Insufficient Monitoring of Transactions

Various state organizations are responsible for monitoring compliance with Medicaid requirements in general and with CFC requirements more specifically. Under Vermont's Medicaid waiver (Global Commitment to Health) AHS is the state agency responsible for ensuring that Medicaid

[18] DAIL changed to a dollar-based budget to comply with a U.S. Department of Labor rule pertaining to home care.

[19] About 43 percent of the amount recouped was from ARIS, while the rest was recouped from other providers.

services are delivered in accordance with federal statutes and the waiver agreement. AHS delegates most of its Medicaid responsibilities to DVHA. The responsibilities of these two parties is contained in an intergovernmental agreement.[20] DVHA, in turn, relies on partnerships with other departments and agencies to provide care to individuals with special healthcare needs, which includes the CFC program. Accordingly, DVHA has an intra-governmental agreement with DAIL specifying each department's responsibilities.[21] DVHA is supposed to monitor DAIL to ensure that it is running compliant programs.

Under Medicaid regulations, the State is required to review the utilization of services. In particular, 42 CFR §456.23 requires the State to have a post-payment review process that identifies exceptions to rectify misutilization practices of Medicaid beneficiaries and providers. According to the AHS/DVHA intergovernmental agreement, DVHA is responsible for having mechanisms in place to detect under- and over-utilization of services.[22] DVHA's mechanisms have not included detailed utilization reviews of CFC's consumer or surrogate-directed services.

Per the DVHA/DAIL intra-governmental agreement effective March 1, 2018, DAIL is required to ensure that those enrolled in CFC have an individual care plan and to monitor adherence to this plan.[23] DAIL's CFC program operations manual includes various monitoring mechanisms that it or a contractor performs (e.g., case managers are required to have monthly contact with the consumer and have face-to-face visits no less than once every 60 days).[24] However, none of these mechanisms include systematically comparing the budget in consumers' care plans to actual expenditures. Instead, the DAIL business office compiles monthly reports comparing CFC's overall budget to the actual amount of expenditures and the number of enrolled individuals.

Medicaid regulations also set forth program integrity requirements (42 CFR part 455 and 42 CFR part H). Medicaid program integrity consists of efforts to ensure that federal and state expenditures are used to deliver quality, necessary care to eligible enrollees, and efforts to prevent fraud, waste, and abuse. For example, according to 42 CFR §455.13, states must have methods and criteria for identifying suspected Medicaid fraud cases. In addition, 42

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20 *Intergovernmental Agreement Between Agency of Human Services and the Department of Vermont Health Access for the Administration and Operation of the Global Commitment to Health Medicaid Demonstration* (April 1, 2017 – December 31, 2017). As of May 22, 2018, this agreement had not been superseded and remained in effect.

21 *Intra-Governmental Agreement For the delivery of services under Vermont's Global Commitment to Health Demonstration Waiver* (DVHA and DAIL, effective March 1, 2018). The prior agreement between DVHA and DAIL was issued in 2006 and was not applicable to CFC because at the time CFC was not part of the Global Commitment to Health waiver.

22 Section 2.10.2 of the AHS/DVHA intergovernmental agreement.

23 Section 3.4 of the DVHA/DAIL Intra-Governmental Agreement (effective March 1, 2018).

24 *Choices for Care Vermont Long-Term Services & Supports Program Operations Manual Highest and High Needs Group* (DAIL, revised May 2015).

CFR §438.608 requires Vermont to establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of Medicaid compliance risks. The State's managed care compliance plan and DVHA's 2018 intra-governmental agreement with DAIL charges DVHA's program integrity unit with conducting reviews, audits, and investigations to assess internal controls and detect instances of suspected fraud, waste, and abuse.[25] This is consistent with the MFRAU memorandums of understanding with AHS and DVHA's program integrity unit.[26]

DVHA's program integrity unit has not performed audits or investigations of consumer or surrogate-directed services. DVHA reported that it takes responsibility for monitoring fraud, waste, and abuse by analyzing MMIS data for anomalies. However, since timesheet data from consumer or surrogate-directed services does not reside in the MMIS, DVHA believes that DAIL is responsible for program integrity activities for this option. This position is not consistent with the State's managed care compliance plan nor DVHA's agreements with AHS, DAIL, or the MFRAU. Moreover, when asked whether it had a program or organizational unit that is responsible for conducting reviews, audits, or investigations related to fraud and abuse for the consumer or surrogate-directed services option, DAIL responded that it does not. DAIL further stated that, consistent with its agreement with DVHA, it reports suspected fraud, waste, and abuse to DVHA's program integrity unit or the MFRAU.

A barrier to reviews of utilization and program integrity by either DVHA or DAIL is the lack of integration of DAIL's service authorization system (SAMS), ARIS's timesheet processing system (FMS Engine), and DXC's claims processing system (MMIS). For example, the ARIS timesheet system contains the attendant's name and dates worked, but this data is not provided to either MMIS or SAMS. Without this data, neither the MMIS nor SAMS on their own can support analyses such as those we performed or to evaluate the extent to which consumers are receiving authorized or unauthorized services.

The lack of an electronic interface between SAMS and MMIS also impedes the State's ability to monitor the appropriateness of consumers' non-ARIS claims. For example, SAMS may contain an authorization for a consumer to receive PCS, companion, or respite care from attendants employed by home health

[25] *Department of Vermont Health Access Managed Care Compliance Plan* (September 1, 2015) and Section 2.7 of the DVHA/DAIL *Intra-Governmental Agreement for the Delivery of Services Under Vermont's Global Commitment to Health Demonstration Waiver* (effective March 1, 2018). The prior agreement between DVHA and DAIL was issued in 2006 and was not applicable to CFC because CFC did not become part of the Global Commitment to Health waiver until 2015.

[26] *Memorandum of Understanding Between Vermont Office of Attorney General Medicaid Fraud & Residential Abuse Unit And Vermont Agency of Human Services* (August 1, 2016) and *Memorandum of Understanding Between Vermont Office of the Attorney General Medicaid Fraud and Residential Abuse Unit And Vermont Agency of Human Services Department of Vermont Health Access Program Integrity Unit* (June 2013).

agencies in addition to attendants paid by ARIS. Home health agencies submit their own claims to MMIS, so the costs from all these claims need to be considered to get the total picture of a CFC consumer's services. During our test of whether consumers had exceeded the annual 720-hour rule for companion and respite care, we found instances of payments to home health agencies for these services even though the consumer's SAMS record indicated that these agencies had not been authorized to provide such care.

ARIS also does not have systematic processes in place to identify suspicious activity patterns. Instead, ARIS officials explained that their employees are encouraged to notice and report suspicious timesheet information or activities and noted that they have submitted suspected fraud referrals to the MFRAU. For example, ARIS staff may notice similarities between the employer and employee signatures on the timesheet or a high number of variances. The ARIS contract in place during the timeframe of our audit required that certain controls be in place (e.g., to inspect timesheets to ensure that they are completed correctly and to regularly remove inactive consumers and attendants from the payroll system). However, there was no contractual requirement that ARIS develop a systematic process to identify potential fraud or abuse. The contract language limited ARIS's responsibility to reporting suspected fraud and abuse in a timely fashion. DAIL's current contract with ARIS (for performance period February 1, 2018 – January 31, 2020) includes this same language plus the following:

> "The Contractor shall have a process to identify, and shall review with the State, basic errors and/or potential fraud, such as:
> i. Employees who have billed duplicate hours for multiple employers or programs;
> ii. Hours submitted which exceed 24 for one day;
> iii. Employers billing overlapping hours for multiple employees.
> iv. Employees with an hourly rate of pay in excess of a specified amount identified by the State."

We solicited the MFRAU's views of enhancing program integrity in the CFC's consumer or surrogate-directed services option. The director of this unit responded that the MFRAU supports any and all efforts to improve and enhance analytics that help identify Medicaid fraud, waste, and abuse. The director added that the MFRAU will work with DVHA's program integrity unit in exploring how they can attain the capability to obtain and analyze data to conduct such analyses for the consumer or surrogate-directed services option. The MFRAU also plans to work with the program integrity unit and ARIS to identify signs and patterns of potential fraud, waste, and abuse.

New Federal Control Requirements for Home-Based Care

The Federal 21st Century Cures Act[27] requires states to implement an electronic visit verification (EVV) system for PCS[28] by January 1, 2019.[29] EVV is a technology solution intended to verify that services billed for home and community-based personal or home health care are for actual visits made. EVV systems verify the (1) type of service performed, (2) date of service, (3) time the service starts and ends, (4) location of service delivery (e.g., using caller-ID or global positioning system), (5) individual providing the service, and (6) individual receiving the service.

An effective, well-planned and implemented EVV system detects and prevents fraud, waste, and abuse and improves the quality of care.[30] For example, the Government Accountability Office reported that Maryland, Texas, and a private sector entity reported that using EVV had resulted in savings.[31] Other reported benefits included collecting data to allow the State to more easily review trends and identify potential service issues and deterring people with nefarious intentions from seeking home care employment.

According to CMS, there are five major EVV system models implemented by states.[32] Vermont intends to use the open vendor model in which covered entities/providers can choose between creating/using their own system or using the state system. Under this model, states are responsible for developing and implementing policies and procedures regarding the EVV program and for maintaining oversight. According to CMS, states implementing the open vendor model would need to develop a data aggregation solution and specify the data to be collected from the providers and managed care plans. Each EVV system would then report standardized data to the state.

DVHA is responsible for the oversight and strategic direction of Vermont's EVV project. The State's May 2018 proposal to CMS for the implementation of this project states that Vermont will procure an EVV solution through an

27 Public Law 114-255 (2016), section 12006. Not implementing an EVV would subject a state to incremental reductions in Federal Medical Assistance Percentage matching of PCS expenditures. Managements' comments on a draft of this report stated that they expect the implementation date to change to January 2020 because of recent Congressional action.

28 Although the Federal requirement is for PCS, the DAIL adult services division director stated that Vermont will likely include companion and respite care as well to maintain continuity across CFC services.

29 EVV is also required to be implemented for home health care services by January 1, 2023.

30 *Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants* (National Association of States United for Aging and Disabilities, May 2018).

31 *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs* (U.S. Government Accountability Office, GAO-17-28, November 23, 2016).

32 CMCS Informational Bulletin, *Electronic Visit Verification* (CMS, May 16, 2018).

amendment to its contract with DXC, which has partnered with another vendor that provides this technology. The State also proposed to integrate the EVV solution to the MMIS and the ARIS timesheet system (FMS Engine). Such integration is expected to allow DVHA's program integrity unit to have the data it needs to perform analyses to prevent, recognize, and mitigate fraud, waste, and abuse.

The EVV project would seem to provide an opportunity to review and reconsider the processes used to authorize and pay for CFC consumer or surrogate-directed services. The current administration has committed to using process improvement tools to develop and implement viable changes, improvements, and action plans to achieve results and efficiency improvements.[33] In mid-June 2018, the DVHA Medicaid compliance officer noted that the State will be documenting a desired "future-state" of the EVV that will include process improvements. The compliance officer stated that the State recognizes the need to link timesheet, EVV, and MMIS claims data. Without additional detail as to how EVV will be implemented, we cannot assess the extent to which this new control will address the myriad weaknesses found during this audit. For example, according to the State's May 2018 EVV proposal to CMS, Vermont does not anticipate modifications to any state system other than the MMIS. This excludes integration with SAMS—the DAIL service authorization system. Without integration with SAMS, it is difficult to see how EVV will address whether claims are for authorized services.

Conclusions

Our comparison of data from several State and contractor systems found payments for home-based care services in the CFC consumer or surrogate-directed services option that were not compliant with State requirements as well as suspicious transactions that could be an indicator of fraud. These improper payments and suspicious transactions resulted from process and control weaknesses. These weaknesses included relying on manual processes, incomplete or flawed system edits, and insufficient monitoring of transactions. DAIL and DVHA could and should make improvements to address each of these weaknesses individually. However, a more holistic approach to the consumer or surrogate-directed services' authorization and payment processes could provide a more effective way forward. The State's plan to implement a new EVV initiative within the next few months seems to provide a timely opportunity to explore additional ways to improve controls and processes.

[33] Executive Order No. 04-17, January 5, 2017.

Recommendations

We make the recommendations in Table 5 to the Commissioner of the Department of Disabilities, Aging and Independent Living:

Table 5: Recommendations and Related Issues for DAIL

Recommendation	Report Pages	Issue
1. Evaluate the improper payments identified during this audit and seek reimbursement when feasible.	12-14	The results of our improper payment tests totaled about $150,000 for a 15-month period.
2. Review the method ARIS uses to process payroll for weeks that include more than 40 hours of work and ensure that attendants are being paid in accordance with DAIL requirements.	12	Our analysis of ARIS's payroll data showed 395 transactions in which overtime was paid even though the total hours paid did not exceed 40 hours. We provided examples of these transaction to ARIS and they explained that some were in error while others occurred due to how they process overtime and budgets. Because of the complicated nature of the ARIS process, it appears to warrant a state review to determine that payroll involving overtime is being properly calculated.
3. Require ARIS to implement a control that enforces the 720-hour limit on companion/respite care unless there is a variance.	17-18	Under CFC rules, companion and respite care is limited to 720 hours in a calendar year unless DAIL approves a variance. FMS Engine lacks an edit to enforce this rule.
4. Submit a request to DXC Technology to modify the MMIS edit that enforces the 720-hour limit on companion/respite care so that it allows a maximum of 2,880 quarter-hour units unless DAIL issues a variance.	17-18	ARIS submits companion and respite claims to the MMIS based on quarter-hour units, so the maximum number of these units permitted without a variance is 2,880. The MMIS edit that checks that the 720-hour maximum is not exceeded without a variance used this figure until October 2017. At that time and at DAIL's request, DXC deployed a change to the MMIS that set the maximum to 5,760 units (1,440 hours)—double the amount allowed in the CFC rules.
5. Submit a request to DXC Technology to develop an MMIS edit to disallow PCS, companion, and respite claims for consumers in a hospital.	18	The MMIS does not have an edit that checks whether home-health claims are submitted for days in which a consumer is in a hospital.

Recommendation	Report Pages	Issue
6. Ensure that the EVV initiative explores ways to improve processes and controls over CFC consumer or surrogate-directed services authorizations and payments.	22-23	The Federal 21st Century Cures Act requires states to implement for PCS an EVV system, which is a technology solution intended to verify that services billed for home and community-based personal or home health care are for actual visits made. Vermont does not plan to modify any state system other than the MMIS. This excludes integration with SAMS—the DAIL service authorization system. Without integration with SAMS, it is difficult to see how EVV will address whether claims are for authorized services. The EVV project provides an opportunity to review and reconsider the processes used to authorize and pay CFC consumer or surrogate-directed option services.

We make the recommendations in Table 6 to the Commissioner of the Department of Vermont Health Access:

Table 6: Recommendations and Related Issues for DVHA

Recommendation	Report Pages	Issue
7. To the extent that improper payments identifed in this report are not recouped within the timeframes required by CMS, report them as overpayments to AHS for reporting to CMS.	12-15	The results of our improper payment tests totaled about $150,000. Per 42 CFR §433, subpart F, the State has one year to recover or seek to recover overpayments from the date of discovery before reporting the overpayment to CMS and returning the federal share to CMS. DVHA is responsible for reporting overpayments to AHS central office, which submits quarterly reports to CMS.
8. In conjunction with DAIL, develop a utilization review process of consumer or surrogate-directed services that checks the extent to which consumers are under- or over-utilizing authorized services at the consumer level. This could be achieved by developing an interface between SAMS and MMIS that allows for the comparison of consumers' service limits and actual claims.	19	42 CFR §456.23 requires the State to have a post-payment review process that identifies exceptions to rectify misutilization practices of Medicaid beneficiaries and providers. According to the AHS/DVHA intergovernmental agreement, DVHA is responsible for having mechanisms in place to detect under- and over-utilization of services. DVHA's mechanisms have not included detailed utilization reviews of CFC's consumer or surrogate-directed services. In addition, per the DVHA/DAIL intra-governmental agreement DAIL is required to ensure that those enrolled in CFC have an individual care plan and to monitor adherence to this plan. DAIL does not systematically compare the budget in consumers' care plans to actual expenditures.

Recommendation	Report Pages	Issue
9. Direct the program integrity unit to work with DAIL, ARIS Solutions, Inc., and the MFRAU to perform periodic analysis of CFC consumer or surrogate-directed services timesheet and payroll data to identify potential areas of fraud and abuse.	20-21	Medicaid regulations contain program integrity requirements (42 CFR part 455 and 42 CFR part H). The State's managed care compliance plan and DVHA's 2018 intra-governmental agreement with DAIL charges DVHA's program integrity unit with conducting reviews, audits, and investigations to assess internal controls and detect instances of suspected fraud, waste, and abuse. DVHA's program integrity unit has not performed audits or investigations of CFC's consumer or surrogate-directed services.

Managements' Comments

On July 25, 2018, we received a joint set of comments from the Secretary of the Agency of Human Services and the Commissioners of the Department of Disabilities, Aging and Independent Living and the Department of Vermont Health Access (reprinted in Appendix III). The comments noted that the recommendations in the report are worthy of consideration and generally achievable.

Appendix I
Scope and Methodology

To address our objective, we first developed an understanding of Medicaid home-based care in general and the Choices for Care program's consumer or surrogate-directed services option in particular by reviewing (1) federal regulations, guidance, and training materials; (2) the Global Commitment to Health Section 1115 Demonstration; (3) Vermont CFC rules; (4) DAIL policies and guidance; (5) contracts between DAIL and ARIS Solutions, Inc.; (6) the 2014 and 2016 collective bargaining agreements between the State of Vermont and Vermont Homecare United, AFSCME; and (7) reports by the U.S. Government Accountability Office and by the U.S. Department of Health and Human Services' Office of Inspector General. We also discussed the application of policies and procedures and processes used to authorize services and approve timesheets and claims with officials from DAIL, ARIS, DXC, and the Central Vermont Council on Aging.

Next, we obtained data from various sources to perform a variety of tests developed from our research. From DAIL, we obtained a file from SAMS—a case management system—that contained the authorization of services for specific consumers with records from July 1, 2016 to September 30, 2017. From ARIS, we obtained files from its timesheet system (FMS Engine) and current and former payroll systems (FEAP and ISO,[34] respectively) that contained records from the pay periods that included services rendered on the days July 1, 2016 through September 30, 2017. From DXC, we obtained a file from the MMIS of paid claims for CFC consumers for services between January 1, 2016 to September 30, 2017. Lastly, we obtained a file of death records between January 1, 2008 to October 11, 2017 maintained by the Vermont Department of Health. We imported these files into IDEA, our data analysis software, and assessed their reliability by reviewing the data to ensure that it was reasonable and accorded with the data requested, with appropriate entries in each field and expected ranges of values. We compared different data sets to each other, for example, to ensure that MMIS claims were similar to costs recorded in ARIS payroll systems and that payroll costs were in turn related to timesheet data. We did not assess the accuracy of timesheets submitted to ARIS nor ARIS's data entry into its systems.

Our tests fell into two categories. We performed tests of compliance with program requirements, as breaches of these requirements would generally result in an improper payment. We also performed tests that looked for suspicious patterns of behavior. These identified activities that may not themselves be directly contrary to explicit program requirements but might

[34] Prior to the scope of our audit (services rendered between July 1, 2016 and September 30, 2017), ARIS had transitioned to FEAP for CFC consumer or surrogate-directed services. Other programs in which ARIS is the payroll/employer agent, such as developmental disabilities services program and children's personal care services program, were transitioned to FEAP later. Some of our tests considered the hours charged to both CFC and non-CFC programs (e.g., our test of whether ARIS paid for services to a recipient through multiple programs simultaneously). Using our IDEA data analysis software, we combined data from both systems into a single payroll file to allow us to perform such analyses.

when viewed collectively, be indicative of some improper activity. The criteria for these analyses were suggested by MFRAU based on their experience investigating and prosecuting Medicaid fraud cases and other research we performed.

Table 7 contains a summary of our tests of compliance, by test objective and system used.

Table 7: Summary of Compliance Tests Performed

Test Objective	SAMS	FMS Engine	FEAP	ISO	MMIS	Death File	Description[a]
Determine whether consumers received PCS for which they were not authorized.	X				X		Compare claims in MMIS to budgets recorded in SAMS and budget adjustments implemented via a spreadsheet in September 2016.
Determine whether consumers received more than 720 hours of companion and/or respite care through ARIS without an authorized variance.	X				X		Compare ARIS companion and respite claims in MMIS to the 720-hour limit, prior authorizations recorded in MMIS, and budgets recorded in SAMS and budget adjustments implemented via a spreadsheet in September 2016.
Determine whether attendants were paid for PCS, respite, or companion services on dates in which the consumer was in a facility (e.g., hospital or nursing home).		X			X		Compare ARIS claims to hospital, nursing home, and hospice claims for inpatient and residential services in MMIS to identify overlapping dates. When claims overlap, compare to timesheet data to determine whether the attendant worked on the applicable dates.
Identify instances of attendants claiming to have provided multiple services or served multiple recipients simultaneously.		X					Analyze timesheet data for overlapping shifts reported by an attendant.
Determine whether attendants were incorrectly paid overtime.		X	X				Analyze payroll data to identify instances of attendants paid overtime for working less than 40 hours in a week.
Determine whether ARIS billed MMIS for services delivered to a CFC consumer after the consumer's date of death.		X			X	X	Compare ARIS claims to consumer death dates as recorded in either MMIS or the death file from the Department of Health. If a claim's date range extends beyond the death date, compare timesheet records to determine whether services were actually recorded as delivered after the death date.

Test Objective	SAMS	FMS Engine	FEAP	ISO	MMIS	Death File	Description[a]
Determine whether ARIS billed MMIS for services delivered by an attendant after the attendant's date of death.		X				X	Compare timesheet data to attendants' death dates as recorded in death file from the Department of Health.
Determine whether ARIS paid attendants in compliance with maximum and minimum wage requirements.			X				Analyze payroll data to identify instances of attendants paid at over the maximum wage or below the minimum wage for the applicable service, as contained in the State's CBAs with Vermont Homecare United, AFSCME.
Determine whether attendants were paid to provide more than 24 hours of care in a single calendar day.		X					Analyze timesheet data to identify instances of attendants paid for more than 24 hours of CFC work in a single day.
Determine whether a consumer received more than 24 hours of care in a single calendar day.		X					Analyze timesheet data to identify instances of consumers for whom more than 24 hours of CFC services were paid for in a single day.
Determine whether ARIS paid any attendant to provide services for a consumer for whom they acted as surrogate employer.			X				Analyze payroll data to identify instances where attendant and employer names match. Analyze payroll data to identify consumers who had multiple employers during the audit period, identify any attendant who also acted as employer, and compare dates for such individuals' services as employer and as attendant.
Identify instances of ARIS paying for services to a consumer through multiple programs simultaneously.			X	X			Summarize payroll data by consumer and week and identify instances of consumers receiving CFC services and services from another program in the same week.

[a] The term "ARIS claims" in this column only refers to claims for CFC consumer or surrogate-directed services.

Table 8 contains a summary of our tests for suspicious transactions, by test objective and system used.

Table 8: Summary of Tests of Suspicious Transactions Performed

Test Objective	SAMS	FMS Engine	FEAP	ISO	MMIS	Death File	Description[a]
Determine whether attendants were paid for providing 20-24 hours of care in a single calendar day.		X					Analyze timesheet data to identify instances of attendants paid for 20-24 hours of CFC services in a single day.

Appendix I
Scope and Methodology

Test Objective	SAMS	FMS Engine	FEAP	ISO	MMIS	Death File	Description[a]
Determine whether attendants were paid for an unlikely number of hours in a given week.			X	X			Analyze payroll data to identify instances of attendants paid for over 100 hours of CFC services in a week.
Determine whether attendants were paid to work an implausible number of days during the period under review (July 1, 2016 – September 30, 2017, or 457 calendar days).		X					Analyze timesheet data to count the number of days on which each attendant was paid for CFC services, and the number of hours for which they were paid.
Determine whether there was a suspicious pattern of usage of authorized companion/respite hours.					X		Analyze ARIS companion and respite claims in the MMIS to identify consumers who used over 90 percent of their 2016 total for these services in the first half of the year.
Identify addresses shared by multiple individuals.			X		X		Compare consumer addresses in MMIS to attendant and employer addresses in payroll data, and identify addresses shared by three or more individuals.
Identify instances when an attendant was paid for multiple periods at the same time.			X				Analyze payroll data to identify instances when an attendant's pay was for four or more different payroll periods.
Identify attendants with addresses not in Vermont or contiguous states.			X				Analyze payroll data for attendant addresses that are not Vermont, New Hampshire, New York, or Massachusetts.
Identify instances of services delivered at an implausible time of day.		X					Analyze timesheet data to identify services delivered between midnight and 5 am.
Identify attendants serving more than one recipient in a day.		X					Analyze timesheet data to identify attendants paid to provide more than 6 hours of CFC services to each of two or more recipients on the same day.
Identify attendants serving more than four recipients in a week			X	X			Analyze payroll data to identify attendants paid for services to more than four recipients in a single week.

Where our analyses identified apparent improper payments or suspicious transactions, we obtained confirmation, explanations, and supporting documentation from ARIS, DAIL, and DXC, as appropriate. In addition, we had online access to MMIS, enabling us to view certain information not included in our data sets. Moreover, to ensure that we had correctly interpreted data, we obtained selected timesheets from ARIS and obtained additional SAMS information or other authorization documentation from DAIL staff.

Appendix I
Scope and Methodology

We limited our evaluation of internal controls, including system controls to following-up on the reasons why identified improper payments and suspicious transactions occurred. More broadly we also reviewed the utilization and program integrity requirements and responsibilities in (1) Medicaid regulations, (2) the intergovernmental agreement between AHS and DVHA, (3) intra-governmental agreements between DAIL and DVHA, (4) the memorandums of understanding between MFRAU and AHS and DVHA's program integrity unit, and (4) DVHA's managed care compliance plan. We conferred with DVHA and DAIL officials about these requirements and how they had been implemented. Lastly, we obtained an understanding of the status of the State's plan to implement an electronic visit verification system and federal requirements pertaining to this type of system.

Our field work was conducted between August 2017 and July 2018, primarily at DAIL's offices in Waterbury, DVHA's offices in Williston, and ARIS offices in White River Junction. We conducted this performance audit in accordance with generally accepted government auditing standards, which 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 II
Abbreviations

AAA	Area Agencies on Aging
AFSCME	American Federation of State, County and Municipal Employees
AHS	Agency of Human Services
CBA	Collective bargaining agreement
CFC	Choices for Care
CMS	Centers for Medicare and Medicaid Services
DAIL	Department for Disabilities, Aging and Independent Living
DVHA	Department of Vermont Health Access
EVV	Electronic visit verification
FEAP	Fiscal Employer/Agent Payroll
HHA	Home Health Agency
MFRAU	Medicaid Fraud and Residential Abuse Unit
MMIS	Medicaid Management Information System
PCS	Personal care services
SAMS	Social Assistance Management Systems

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Al Gobeille, Secretary

July 25, 2018

Mr. Douglas R. Hoffer
Vermont State Auditor
Office of the State Auditor
132 State Street
Montpelier, Vermont 05633-5101

Dear Mr. Hoffer:

Thank you for sending the draft report of your audit *Choices for Care: Improved Controls and Processes Could Reduce Risk of Improper Payments and Suspicious Transactions*. We recognize that there is national concern about compliance, payment and fraud vulnerabilities associated with the provision of home-based care and that it was important for your office to assess whether improper payments were made under the Choices for Care Program's consumer or surrogate directed care options.

Vermont is considered a national leader in the delivery of long term services and supports, not only in Choices for Care, but other programs as well. In 2017, Vermont was ranked third in the nation by the AARP Long Term Services and Supports Scorecard. DAIL also received the SCAN Foundation Pacesetter Award for improving access and affordability. One of the ways that we have built a successful long term care program has been through reliance on consumer-directed service options. In the Choices for Care Program, people are given choices among different service settings and service options. About 55% of people using personal care choose to use consumer or surrogate-directed services rather than home health agency services. The lower costs of these services represent avoided costs of more than $13 million a year, as compared to the costs of home health agency services, and additional avoided costs due to reduced nursing home use. This service model helps to address our workforce shortage by bringing family members and friends into the caregiver workforce. Consumers generally rate choice, control, and quality of consumer-directed services higher than other service options. In 2018, Vermont joined the National Core Indicators for aging and disability services, which will provide new data on quality of care and quality of life.

We have reviewed the draft report with our senior staff. Overall, we found the report to be accurate. The recommendations contained in the report are worthy of consideration and generally achievable. Clearly, there are opportunities to strengthen our management of consumer-directed services across AHS programs. As you requested, we have provided comments on the findings, conclusions and recommendations, and have also outlined the actions we plan to take in response to the recommendations in the report.

Sincerely,

Al Gobeille
Secretary
Agency of Human Services

Monica Caserta Hutt
Commissioner
Department of Disabilities, Aging and Independent Living

Cory Gustafson
Commissioner
Department of Vermont Health Access

AHS Response to Vermont State Auditor's Report: Choices for Care: Improved Controls and Processes Could Reduce Risk of Improper Payments and Suspicious Transactions (July 2018)

Background:

See SAO comment 1 on page 39.

Thank you for the opportunity to respond to the 2017-2018 Choices for Care audit of self-directed home-based services. Clearly, the audit was complex, requiring more than a year to complete. Additionally, audit samples fell primarily in the middle of a large and complex program transition from hourly authorizations to budget authorizations. Below are some contributing facts that may provide useful background on some of the findings:

- Transition to Budgets: In April 2016, DAIL changed how Choices for Care Home and Community Based Services (HCBS) service authorizations were managed. Until April 2016, companion/respite services were managed and entered into the SAMS database using hourly increments. For example, a person with 720 hours per year would be entered into the Care Plan as 60 units (hours) per month. After April 2016, service authorizations changed from service hours to service budgets, and program staff were required to enter services using dollar increments. This required staff to manually calculate each budget based on a standard unit rate and then manually enter budget figures into SAMS. For example, a standard hourly rate of $12.76 for 720 hours per year would produce an authorized budget of $9,187.20 per year for respite/companion services.
- Rate Changes: After Choices for Care HCBS service authorizations transitioned from service hours to service budgets in April 2016, the standard rate used to create respite/companion budgets changed two more times. Each change required program staff to modify their calculations to properly enter the companion/respite budgets in SAMS. The table below shows the standard rate changes in 2016.

COMPANION/RESPITE	$ /year	Dates
720 hrs/year @ $12.24/hour	$ 8,812.80	7/6/14-7/2/16
720 hrs/year @ $12.51/hour	$ 9,007.20	7/3/16-9/10/16
720 hrs/year @ $12.76/hour	$ 9,187.20	9/11/16-6/30/2018

- Overtime: From the implementation of the new Department of Labor (DOL) overtime rules in November 2015 through the start of budgets in April 2016, ARIS was required by law to pay overtime for any employee that submitted more than 40 hours in a work week. DAIL agreed to cover emergency overtime until new budgets were allocated and service plans could reflect the ongoing, additional need. These overtime costs would not be captured in SAMS care plans and may have forced MMIS claims to exceed budgets in SAMS without a variance. After April 2016, employers were instructed to submit a variance request to increase their budget if they required overtime. Additionally, DAIL was required to increase the MMIS maximum service caps to accommodate claims for overtime.

General comments:

See SAO comment 2 on page 39.

It would be helpful to include definitions of "improper payment" and "suspicious transactions" in the document. CMS has defined 'improper payments' as follows:

"An improper payment is defined as any payment made:

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• In error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;
• To an ineligible beneficiary;
• For ineligible goods or services;
• For goods or services not received (except for such payments where authorized by law);
• That duplicates a payment;
• That does not account for credit for applicable discounts;
• Without supporting documentation; and
• Where documentation is missing or not available."
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2016MedicaidandCHIPImproperPaymentReport.pdf

DAIL treats every incident of fraud, waste or abuse seriously, and pursues an error rate of 0%. However, we do note that the auditor's findings of $150,000 of improper payments within total payments for CFC services through ARIS of $24.7 million during the period represents an error rate of 0.6%. This rate compares favorably with the national Payment Error Rate Measurement Program (PERM) Medicaid Improper Payment Rates published by CMS, as the 'Rolling National Medicaid Improper Payment Rate' in fee for service payments was 12.9% for 2014-2016 (the official rate reported by CMS and published in November 2017).
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2017PERMMedicaidImproperPaymentRates.pdf

See SAO comment 3 on page 39.

The improper payment rate of 0.6% in the ARIS claims also compares favorably with the improper payment rate for Medicaid personal support service claims, which was projected by CMS to be 17.4% in November 2016.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2016MedicaidandCHIPImproperPaymentReport.pdf

Examples of improper or suspicious payments described in the report (and contained in Tables 1-4) appear to be similar to and/or consistent with examples included in the OIG national report (US HHS OIG, Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement), but without definitions in the report it is unclear if they are, in fact, consistent. Additionally, under the authority given to individual employers in Vermont, it is not clear how many of these payments are actually "improper" under applicable statutes, regulations, standards and guidelines.

See SAO comment 2 on page 39.

Accessibility: DAIL pursues accessibility in public documents, including accessibility for people who are blind or have visual impairments. DAIL notes that the font size used throughout the document is very small and may not be accessible to all readers. We encourage the use of an accessible font size throughout the document.

Response to Recommendations:

Recommendation #1:

Evaluate the improper payments identified during this audit and seek reimbursement when feasible.

DAIL Response #1: As set forth in the DVHA-DAIL IGA, DAIL staff will continue to make referrals to DVHA's Program Integrity Unit whenever becoming aware of potential fraud, waste or abuse. DAIL will cooperate with the DVHA Program Integrity Unit to evaluate improper payments that were identified and to seek reimbursement when feasible. Target Date: January 2019.

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Recommendation #2:

Review the method ARIS uses to process payroll for weeks that include more than 40 hours of work and ensure that attendants are being paid in accordance with DAIL requirements.

DAIL Response #2: DAIL will review the overtime calculation methodology with ARIS and require changes to be made to the methodology required by federal and state law, as necessary. We note that under federal and state law, overtime must be calculated on the basis of all hours worked for an employer, including hours worked under all programs and services. Target Date: January 2019.

Recommendation #3:

Require ARIS to implement a control that enforces the 720-hour limit on companion/respite care unless there is a variance.

DAIL Response #3: DAIL acknowledges that under CFC regulations and the Global Commitment Special Terms and Conditions, companion and respite care is limited to 720 hours in a calendar year unless DAIL approves a variance. DAIL will request that ARIS implement an edit to enforce this rule in their Fiscal Management System. Target Date: January 2019

DAIL Recommendation #4:

Submit a request to DXC Technologies to modify the MMIS edit that enforces the 720-hour limit on companion/respite care so that it allows a maximum of 2,880 quarter-hour units unless DAIL issues a variance.

DAIL Response #4: DAIL acknowledges that under the current CFC regulations and the current Global Commitment Special Terms and Conditions, companion and respite care is limited to 720 hours in a calendar year unless DAIL approves a variance. DAIL will work with DVHA and DXC to develop a solution to the problem of companion/respite overpayments. Solutions may include an MMIS claims edit control that will prevent companion/respite overpayments or a method to evaluate retrospective payments for errors and recoupments on a regular basis. Target Date: Plan developed by January 2019. Implementation date will depend on the solutions.

DAIL Recommendation #5:

Submit a request to DXC Technologies to develop an MMIS edit to disallow PCS, companion, and respite claims for consumers in a hospital.

DAIL Response #5: DAIL acknowledges that the MMIS does not have an edit that checks whether claims are submitted and paid for days in which a consumer is in a hospital. Though some overlap is allowed on the day of admission and discharge, DAIL will work with DVHA and DXC to avoid payments during hospital stays and to identify an MMIS solution to prevent payment for improper claims. Target Date: January 2019. This depends on DVHA and DXC timetable. Implementation date will depend on the solutions.

DAIL Recommendation #6:

Ensure that the EVV initiative explores ways to improve processes and controls over CFC consumer and surrogate-directed service authorizations and payments.

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DAIL Response #6: DAIL will continue work with DVHA on the design and implementation of EVV, including exploring ways to improve processes and controls over CFC consumer and surrogate- directed service authorizations and payments. Target Date: January 2020. Implementation date is expected to change from January 2019 to January 2020 by recent Congressional action.

DVHA Recommendation #7:

To the extent that improper payments identified in this report are not recouped within the timeframes required by CMS, report them as overpayments to AHS for reporting to CMS.

DVHA Response #7:

Once DAIL confirms the internal control numbers for all claims that require recoupment, DVHA Program Integrity will follow their process for recoupment of funds for these claims. Target date: January 2019.

DVHA Recommendation #8:

In conjunction with DAIL, develop a utilization review process of consumer and surrogate-directed services that checks the extent to which consumers are under or overutilizing authorized services at the consumer level. This could be achieved by developing an interface between SAMS and MMIS that allows for the comparison of consumers' service limits and actual claims.

DVHA Response #8:

Until CFC data is available in the MMIS, DVHA and DAIL will collaborate to design a crosswalk methodology to bridge SAMS service approval, ARIS payroll data, and MMIS paid claims. Implementation of this methodology will be driven by the availability of staff and other resources. DVHA and DAIL will also consider opportunities to address this issue in activities that align CFC with the All Payor Model, as required by the legislature. Target date: Initial design July 2019.

DVHA Recommendation #9:

Direct the program integrity unit to work with DAIL, ARIS Solutions, Inc., and the MFRAU to perform periodic analysis of CFC consumer or surrogate-directed services timesheet and payroll data to identify potential areas of fraud and abuse.

DVHA Response #9:

As set forth in the DVHA-DAIL IGA, DAIL staff will cooperate with DVHA's Program Integrity Unit to identify potential fraud, waste and abuse. Until CFC data is available in the MMIS, DVHA and DAIL will collaborate to design a crosswalk methodology to bridge SAMS service approval, ARIS payroll data, and MMIS paid claims. Implementation of this methodology will be driven by the availability of staff and other resources. DVHA and DAIL will also consider opportunities to address this issue in activities that align CFC with the All Payor Model, as required by the legislature. Target Date: Initial design July 2019.

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SAO Evaluation of Managements' Comments

SAO Comment 1.	Managements' response cites a variety of program changes, most of which were complete by April 2016, before the starting dates of most of our tests (July 2016).
SAO Comment 2.	The definition of improper payments provided in managements' response is broader than the scope of our audit. For example, it includes payments on behalf of an ineligible beneficiary and the lack of supporting documentation, which we did not review. Our focus was evaluating and comparing data from authorization, timesheet, payroll, and claims systems to DAIL criteria. As a result, we did not include the suggested definition in our report, but we did add the part of the definition of improper payment that applied to our work—payments made in error or an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. As to the definition of suspicious transactions, our report explained that these resulted from improbable circumstances that we identified through discussions with the MFRAU and our research, so no change was made.
SAO Comment 3.	Management is incorrect to represent our findings as an error rate. As explained in comment 2, our scope did not include substantial areas of potential improper payments, so our results are not comparable to the CMS error rates cited in the comments. Moreover, managements' response does not take into account the many suspicious transactions that were found and referred to the MFRAU. If the MFRAU's investigations into these cases should find fraudulent or abusive actions on the part of attendants and/or employers there would be more improper payments than the $150,000 cited in this report.