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Wm. Jeff Kahrs, Interim-Acting Secretary

Sam Brownback, Governor

January 11, 2012

Re: Final Report – The Whole Person (11WHOLEPMPABF)

Mr. Steve Leary, Director, SRS Community Supports and Services
Docking State Office Building, 9th Floor
915 SW Harrison
Topeka, KS 66612

Mr. Micheal Donnelly, Director, SRS Rehabilitation Services
Docking State Office Building, 9th Floor
915 SW Harrison
Topeka, KS 66612

Dear Mr. Leary and Mr. Donnelly:

The SRS Office of Audit and Consulting Services (OACS) has recently completed its audit of The Whole Person for the period July 1, 2008 through June 30, 2010. Our audit focused on controls and compliance over the payroll agent functions and billing for waiver services.

We issued out Draft Report to The Whole Person on November 22, 2011. We received a response on December 22, 2011. We have reviewed this response and it into our Final Report.

In their response, The Whole Person disagreed with our disallowance of claims in which it appeared the Personal Care Attendant signed for the consumer to whom they provided services. The Whole Person indicated the consumer signed a document verifying the signature on these timesheets was their own. We reviewed these documents and determined the consumer signed the forms verifying "this is a true and accurate timesheet(s) reflecting the actual time worked and tasks performed on said timesheet(s)." The document further stated "By signing below I acknowledge my review of said timesheet(s) and attest to its validity". Based on this information, we made no adjustments to our findings.

SRS Program staff should monitor the implementation of corrective actions at The Whole Person. SRS Community Supports and Services should contact the Kansas Department of Health and Environment regarding the audit findings related to questioned Medicaid payments. Our audit identified questionable, known and potential, Medicaid payments to The Whole Person totaling $139,486.67.

OACS will be using TeamCentral to followup on these recommendations throughout the next six months.

Thank you for all the help you provided throughout the audit. Please convey to your staff our appreciation for their assistance during the audit. If you have any questions regarding this audit please contact me at (785) 296-6805 or electronically at Chris.Johnson@srs.ks.gov.

Best regards,

Christopher S. Johnson, CIA, CPM, Assistant Director

cc: David Robinson, Executive Director, The Whole Person
Donna Miller, Chief Financial Officer, The Whole Person
Board of Directors, The Whole Person
SRS Audit Committee
Phyllis Gilmore, Director, Kansas City Metro Regional SRS Office
Greg Wintel, SRS Community Supports and Services
Maia Ruby-Clemmons, SRS Rehabilitation Services
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Final Audit Report

The Whole Person

For the period: July 1, 2008 through June 30, 2010

Report Issued: January 11, 2012

For Additional Information, Contact:

Shirley Chung, Auditor
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INTRODUCTION

The audits of the Centers for Independent Living (CIL) were jointly requested by the Director of Rehabilitation Services (RS) and the Director of Community Supports and Services (CSS). The Directors requested all CILs be completed based on audit results at other facilities. These audits were to be completed in two parts: Billing of claims, and activities related to Rehabilitation Services grants. For this provider, only the Medicaid Billing portion was completed as they received no grant funds from RS.

These audits included The Whole Person (TWP) located in Kansas City. CSS staff reported they felt billing for this provider was good. This provider served clients from Kansas and Missouri. There were concerns reported about potential differences in operations because two states, with potentially different requirements, were served.

Based on the request from program staff, the Office of Audit and Consulting Services developed the following objectives:

1. Has the CIL established adequate controls to ensure its payroll agent function complies with Medicaid regulations and established policies and procedures?
2. Has the CIL established adequate controls to ensure billing of Home and Community Based Services (HCBS) claims is in accordance with Medicaid regulations and SRS and Waiver requirements?

This audit covered claims submitted to and paid by Medicaid for services provided between July 1, 2008 and June 30, 2010. For the Payroll Agent functions, we compared actions and documentation to Medicaid requirements in the Provider Agreement and as indicated in the Kansas Medical Assistance Program Provider Manuals for the various waiver services provided. We determined whether providers maintained documentation as required and paid the Personal Care Attendants (PCA) correctly and only for services provided. Our work included reviewing personnel files, payroll records and consumer timesheets.

For the Medicaid billing objective, we selected a statistically valid sample of paid claims and traced these claims to supporting documentation. Our sample included Personal Services, Overnight Support, and Targeted Case Management. We determined whether the services recorded adequately documented the services billed to and paid by Medicaid. Our audit included reviewing data for overlapping services and services provided by spouses or guardians.

Our audit included only determining whether documentation supporting claims existed and the documentation met the Medicaid requirements. Our audit did not include an evaluation of the necessity for services, the level of care provided, or the types of services approved.

This audit was performed in accordance with Government Audit Standards (2011 revision), the Standards for the Professional Practice of Internal Auditing promulgated by the Institute of Internal Auditors, generally accepted auditing standards, and all other applicable federal and state regulations and policies. The audit included such tests of the records and controls as considered necessary under the circumstances to establish our conclusions.

AUDIT RESULTS

CONCLUSIONS

We identified control weaknesses related to The Whole Person's Payroll Agent functions. These weaknesses included:

- No documentation indicating whether consumers requested or declined background checks for the PCAs providing them services.
- Timesheets submitted by consumers/PCAs being changed by TWP staff without the permission or notification of the PCA or consumer.

These weaknesses increased the risk Medicaid requirements were not met and PCAs may not have been paid correctly.

The Whole Person had not established adequate controls to ensure only services completed in accordance with requirements were billed to Medicaid. We noted the following areas of noncompliance:

- Timesheets submitted for Personal Services and Overnight Support did not always support the number of units billed to Medicaid.
- Some of the sampled Targeted Case Management logs lacked the signature of the case worker as required by Medicaid.
- PCAs reported overlapping services for the same consumer which was not approved in the consumer's Plan of Care.
- Instances in which it appeared the PCA or someone other than the consumer signed the timesheet for the consumer indicating services were performed as indicated.

As a result, TWP received known questioned payments of $62,674.67. Based on the rate of error, we determined additional potential questioned costs of $76,812. We determined total questioned costs, known and potential, to be $139,486.67.

FINDINGS AND RECOMMENDATIONS

Has the CIL Established Adequate Controls to Ensure Its Payroll Agent Function Complies with Medicaid Regulations and Established Policies and Procedures?

Controls Lacking Regarding Background Checks. The KHPA Provider Agreement states:

> *Medicaid providers who choose to provide payroll agent services to self-directed beneficiaries must comply with the following:*
> - *Assist in the completion of background checks on the self-directed attendants working with the beneficiary, at the request of the beneficiary.*

It was noted that background checks were not a requirement but a task which must be completed upon request by the consumer.

As part of the hiring process, background release forms may be completed by the PCA. These forms allow The Whole Person to perform background checks, as requested by the consumer. We found completed background release forms in only 15 of the 35 (43%) of the files reviewed. The remaining files provided no information as to whether or not a background had been requested and completed or never requested.

The Whole Person had not established a process to document:

- Instances in which no background check was requested.
- Instances in which a background check was requested, the date and the results.

Because of this lack of documentation, we could not determine whether background checks were being performed as required by the Provider Agreement. The Whole Person staff indicated they received very few requests for a background check as many of the consumers already knew the person chosen to serve as their PCA.

Timesheets May Be Changed Without Consent or Notification of Consumer or PCA. The Medicaid Provider Manuals for Personal and Night Support Services state:

> *Each timesheet must have a signature of the beneficiary or designated signatory verifying that the beneficiary received the services and that the time recorded is accurate.*

Medicaid and The Whole Person required this signature to be on the timesheet at the time of submission. The Whole Person policies indicated timesheets would not be accepted without these signatures.

During our review of The Whole Person policies and procedures, we determined payroll and billing staff could change figures on the timesheet without notification of the consumer or PCA. In most instances, these changes were corrections made as the result of addition errors.

Based on the ability of The Whole Person staff to change timesheets after submission and approval by the consumer and PCA, we determined an increased risk that claims could be billed based on timesheets which had been altered. This could result in Medicaid paying for services which never occurred or did not occur to the level submitted.

Our review of the Payroll Agent function included only activities related to ensuring PCAs were paid properly. As part of the second audit objective, we traced Medicaid claims to supporting timesheets. Any differences or changes would have been identified during this testing.

Recommendations:

1. The Whole Person should develop a process to document whether background checks have been requested and if so, the date the check was completed and the results shared with the consumer. Hiring packet forms could be revised to include a space for the consumer to indicate whether or not a check is needed. This notation could then be signed off by the consumer. In addition, a system should be set up to document when a background check is initiated and the date the results are shared with the consumer. Having this type of tickler system will help to ensure all requests are handled (completed) and shared with those needing the information.
2. The Whole Person should modify its processes regarding the correction of timesheets without notification of or involvement by the consumer. Options include:
   - Not accepting the timesheet as submitted. This would involve returning the timesheet to the consumer for corrections prior to processing.
   - Notifying the consumer of the errors and documenting their consent to change the timesheet. Following the conversation, the consumer should be notified to submit a revised and corrected timesheet, allowing the processing of timesheets to continue. A tracking system would need to be set up to ensure revised timesheets are submitted.

Has the CIL Established Adequate Controls to Ensure Billing of Home and Community Based Services (HCBS) Claims is in Accordance with Medicaid Regulations and SRS and Waiver Requirements?

Sampling Methodology. In order to determine whether claims were being properly billed to Medicaid by The Whole Person, we requested and obtained a list of all Waiver claims paid during the audit period. We calculated a statistically valid sample size from the total population – 179 claims – and randomly chose claims for the service types within that total sample size. That data is below:

Type of Service	Total Number of Claims	Total Dollar Amount Paid	Sampled Number of Claims	Dollar Amount Paid for Sampled Claims
Personal Services	11,730	$6,411,030.93	100	$61,410.42
Overnight Support	3,595	$936,316.00	39	$10,648.80
Targeted Case Management	3,790	$233,833.74	40	$3,050.68
Total	**19,115**	**$7,581,180.67**	**179**	**$75,109.90**

It is important to remember that each sampled claim may contain multiple units of service that were delivered. Our audit sampling included testing at the claim level which was made up of units of service. That sampling was then extrapolated to the entire population of units and/or claims to arrive at our audit conclusions.

Unsupported Claims Billed and Paid. The Medicaid Provider Manuals state in Section 8400, *Documentation Requirements*:

> *Written documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Providers are responsible to ensure service was provided prior to submitting claims.*
>
> *Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.*

Timesheets were used by Whole Person to support Personal Assistance and Overnight Support Claims. For Targeted Case Management, case logs were to be generated by the Case Manager.

We reviewed the sampled claims submitted for reimbursement and found:

- 14.5 units of Personal Services had no supporting timesheets. Unsupported services represented less than 1% of the total Personal Services units sampled (5,041.75). Payments for these unsupported services totaled $181.83. These errors resulted in four Personal Services claims being incorrectly billed to and paid by Medicaid.
- One unit of Overnight Support could not be supported. This service represented less than 1% of the total units of Overnight Support services sampled (360) and represented a payment of $30.60. This error impacted one claim.
- 7 units of Targeted Case Management could not be supported. These services related to one consumer whose case file could not be found and provided. These units represented 2.3% of the total Targeted Case Management units sampled (279.5) and had a value of $74.20. As a result, one claim was incorrectly billed to and paid by Medicaid.

We identified several causes for the submission of unsupported claims:

- Timesheets contained addition errors which were not identified and corrected prior to submission.
- Supporting documentation was not adequately maintained to ensure it was available for review.
- Entries were possibly miskeyed prior to submission.

Targeted Case Management Logs Not Properly Completed. The Targeted Case Management Provider Service Manual detailed, in Section 8400, the documentation requirements for TCM services. Specifically it stated:

> *An Activity Log that includes:*
>
> - *Case Manager's legibly printed name and signature on each page of the case log verifying that every entry reflects activities performed.*

Of the 40 TCM case logs reviewed, we found 4 (10%) in which one or more entries in the case file were not signed by the Case Manager as required.

It appeared the case logs were not being adequately reviewed and this policy enforced. As a result, there was an increased risk the records could have been completed after the fact or have been prepared by someone other than the case manager.

We determined these four claims were incorrectly billed to and paid by Medicaid because they did not contain the required information. This resulted in payments totaling $166.92, for 16.5 units of TCM, being incorrectly paid to The Whole Person.

Overlapping Services by PCA. The HCBS Provider Manuals stated in Section 8400:

> *No more than one personal service worker may be paid for services at any given time of the day. Exceptions must be justified and documented by the case manager, such as two-man lift for safety issues.*

In our sample of timesheets, we identified 7 instances in which timesheets indicated two different PCAs were working with the same consumer at the same time. These overlaps could indicate:

- The consumer allowed two PCAs to serve them simultaneously even though Medicaid regulations and The Whole Person policies prohibit it. In these cases, the consumer knowingly approved unallowed services.
- The consumer knowingly signed a timesheet for a PCA who did not provide services.
- The consumer did not adequately review the timesheets for all PCAs prior to signing as required as a part of self-directing services.

These overlaps accounted for 23.25 units of service (one was a unit of Overnight Support) being improperly billed to and paid by Medicaid. The monetary impact was determined to be $307.43.

The Whole Person had a process in place to review and identify possible overlap. However, this process was not effective or not followed allowing these overlapping times to be billed to Medicaid.

Impact of Incorrectly Billed Services

During our review of Medicaid Claims, we found the following instances in which claims were paid for services which were not provided or documented in accordance with Medicaid criteria:

Type of Finding	Known Questioned Costs
Unsupported Personal Assistance Claims	$181.83

Type of Finding	Known Questioned Costs
Unsupported Overnight Support Claims	$30.60
Unsupported Targeted Case Management Claims	$74.20
TCM Services not Signed by Case Manager	$166.92
Overlapping Services to the Same Consumer	$307.43
Total	**$760.98**

Our sample of 179 identified 15 claims (8.38%) which contained errors or failed to meet Medicaid requirements. For the two year period audited, Whole Person submitted and was paid for 19,115 claims. By applying the error rate to the population, 8.38% or 1,602 claims were potentially billed and paid incorrectly.

However, we determined the fiscal impact of these errors to be much lower. We sampled payments totaling $75,110. As shown in the table above, known questioned costs totaled only $761 or 1.01%. Applying this error rate to all amounts paid during the audit period resulted in total potential questioned costs of $76,812.

Questionable Consumer Signatures on Timesheets. The Medicaid Provider Manuals indicated all timesheets must be signed by the consumer. Specifically, they stated:

> *In all situations, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided in recognition that a beneficiary's limitations may make assistance necessary in carrying out this function. A designated signatory may be anyone who is aware services were provided. The individual providing the services* ***cannot*** *sign the timesheet on behalf of the beneficiary.*

One of the tasks to be completed by The Whole Person staff prior to submitting timesheets for payroll and Medicaid billing was to review the timesheet for the consumer's signature. However, this check only reviewed the timesheet for the presence of a signature and not whether it actually belonged to the consumer.

During our review of timesheets, we identified five timesheets for three consumer/PCA pairs where the signatures of the PCA and the consumer appeared similar. For each of these timesheets, it appeared the PCA signed for the consumer. We expanded testing in this area because of these initial results and requested all timesheets for these three consumer/PCA pairs for the audit period.

Our additional test results, as outlined in the following table, led us to conclude that PCAs were signing individual consumer names for an extended period of time.

Consumer Initials	PCA	Period Found to Have Signed	Total Claims Paid for Questioned Services
D.S.	Shauna Smallwood	7/12/08 – 6/30/10	$38,728.35
B.G.	Helen Gager	12/12/08 – 6/30/10	$16,135.18
J.T.	Lyana Taylor	12/26/09 – 6/30/10	$7,050.16
Total			$61,913.69

We provided this information to The Whole Person staff. Following the onsite work, the Whole Person staff contacted the consumers for the timesheets and periods in questions. The Whole Person staff obtained signed documents from the consumers indicating they had received the services on the dates in question. A separate acknowledgement was signed for each time sheet in the questioned period. However, we noted the consumer signatures on the documents verifying the services occurred still appeared different from the consumer's signature on the timesheet.

Although Whole Person provided additional information that allegedly supported the services, we continued to disallow these claims based on the following:

- We question the ability of the consumers to remember services provided to them, specifically exact dates and times, nearly three years ago. OACS staff was onsite in January 2011.
- The KMAP Provider Manual stated in section 8400 Documentation Requirements:

  Written documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time in not acceptable. Provides are responsible to ensure service was provided prior to submitted claims.

Amounts determined to have been paid based on potentially fraudulent signed timesheets totaled $61,913.69.

Summary of Known and Potential Questioned Costs

Our audit identified questioned costs of $139,486.67 as detailed in the following table:

Known Questioned Costs Identified Related to Errors or Noncompliance	$ 760.98
Additional Questioned Costs Based on Rate of Error	$76,812.00
Known Questioned Costs for Signatures which were not the Consumers'	$61,913.69
Total Questioned Costs	**$139,486.67**

Recommendations:

- The Whole Person should compare in/out times with totals on timesheets to ensure they match prior to billing. Methods for maintaining and storing supporting documentation should be reviewed to ensure timesheets and case logs can be found when needed for review.
- The Whole Person should review the Medicaid signature requirements with its case managers. Records should be reviewed to ensure they are being properly signed off.
- The Whole Person should review and evaluate its process regarding identifying and correcting reported overlap by PCAs. Timesheets submitted by all PCAs serving a consumer should be gathered and looked at for overlap. As much as possible, none of these timesheets should be processed until all have been received and reviewed. Overlapping timesheets should be returned to the PCA and the consumer notified as the consumer signs the timesheet indicating times are accurate.
- The Whole Person should establish a process to verify questionable signatures. At the time the consumer chooses The Whole Person as the Payroll Agent, a signature should be obtained. This signature should be maintained in an easily accessible location for comparison purposes. It may be necessary to update this form as the consumer ages or their condition changes. Upon receipt of the timesheet, The Whole Person staff should perform a quick comparison of the PCA and consumer signatures on the timesheet. If they appear similar, the consumer's signature should be compared to the one on file. Questionable timesheets should not be processed. Consumers and PCAs should be reminded of the requirements and the consequences for not adhering to them.
- SRS CSS staff should forward the results of this audit to the State Medicaid Agency with a recommendation to recoup funds totaling $139,486.67.

Shirley Chung, Auditor

Chris Johnson, CIA, CPM, Assistant Director

Mary S. Hoover, CPA, CIA, CFE, CGFM, Cr.FA
Audit Director