



JUN - 3 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Review of Medicaid Personal Care Services Claims Made by Providers in New York City (A-02-07-01054)

Attached is an advance copy of our final report on our review of personal care services claims made by providers in New York City under the New York State (the State) Medicaid program. We will issue this report to the State within 5 business days.

Our objective was to determine if the State properly claimed Federal Medicaid reimbursement for personal care services claims submitted by 100 providers in New York City. Our audit period covered January 1, 2004, through December 31, 2006.

The State improperly claimed Federal Medicaid reimbursement for some personal care services claims submitted by providers in New York City. Of the 100 claims in our random sample, 80 claims complied with Federal and State requirements, but 18 claims did not. We could not determine if the remaining two claims, which involved services under the State's Consumer Directed Personal Assistance Program (CDPAP), complied with Federal and State requirements. Based on our sample results, we estimate that the State improperly claimed \$275,327,274 in Federal Medicaid reimbursement.

This overpayment occurred because the State did not adequately monitor New York City's personal care services program for compliance with certain Federal and State requirements.

We recommend that the State:

- refund \$275,327,274 to the Federal Government,
- work with the Centers for Medicare & Medicaid Services to resolve the two CDPAP claims,

- improve its monitoring of New York City’s personal care services program to ensure compliance with Federal and State requirements, and
- promulgate specific regulations related to claims submitted under the CDPAP.

In its comments on our draft report, the State disagreed with our first recommendation and agreed with our remaining recommendations. The State also disagreed with many elements of our findings. The State indicated that the claims in our sample were “substantially in compliance” with Federal regulations and that Department of Health social services districts throughout the State strive to meet the State’s regulations. In addition, the State provided us with additional documentation for certain sample claims. After reviewing the State’s comments on our draft report and additional documentation, we revised our findings and modified our statistical estimates accordingly.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through e-mail at James.Edert@oig.hhs.gov. Please refer to report number A-02-07-01054 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

JUN - 8 2009

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-07-01054

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Personal Care Services Claims Made by Providers in New York City." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228, or through e-mail at John.Berbach@oig.hhs.gov. Please refer to report number A-02-07-01054 in all correspondence.

Sincerely,

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
PERSONAL CARE SERVICES
CLAIMS MADE BY PROVIDERS
IN NEW YORK CITY**



Daniel R. Levinson
Inspector General

June 2009
A-02-07-01054

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New York State (the State), the Department of Health (DOH) administers the Medicaid program. Within DOH, the Office of Long Term Care oversees the personal care services program. Each county's social services district is responsible for authorizing personal care services, arranging service deliveries, and monitoring the personal care services program. In New York City (comprising Bronx, Kings, New York, Queens, and Richmond counties), the Human Resources Administration is responsible for the personal care services program.

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to individuals in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State. Pursuant to the State's regulations: (1) personal care services must be authorized and reauthorized based on a physician's order, nursing assessment, and social assessment; (2) a physician, physician's assistant, or nurse practitioner (medical professionals) must examine the beneficiary within 30 days before the physician's order is signed; and (3) the delivery of personal care services must be supervised by a registered professional nurse. Examples of personal care services include cleaning, shopping, grooming, and bathing.

OBJECTIVE

The objective of our review was to determine if the State properly claimed Federal Medicaid reimbursement for personal care services claims submitted by 100 providers in New York City. Our audit period covered January 1, 2004, through December 31, 2006.

SUMMARY OF FINDINGS

The State improperly claimed Federal Medicaid reimbursement for some personal care services claims submitted by providers in New York City. Of the 100 claims in our random sample, 80 claims complied with Federal and State requirements, but 18 claims did not. We could not determine if the remaining two claims, which involved services under the State's Consumer Directed Personal Assistance Program (CDPAP), complied with Federal and State requirements and are setting aside those claims for resolution by CMS and the State.

Of the 18 noncompliant claims, 1 contained more than one deficiency:

- For eight claims, a medical professional did not examine the beneficiary within 30 days before the order for personal care services was signed.
- Four claims contained no nursing assessment.
- For four claims, there was no nursing supervision.
- For three claims, there was no physician's order.

Of the 100 claims in our sample, 2 were CDPAP claims for which there were no applicable nursing assessments. These two claims are being set aside for resolution by CMS and the State because it is unclear whether State requirements regarding nursing assessments (18 NYCRR § 505.14) apply to CDPAP claims.

These deficiencies occurred because the State did not adequately monitor New York City's personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State improperly claimed \$275,327,274 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period.

We conducted interviews with 65 of the 100 sampled beneficiaries. Of the 65 beneficiaries interviewed, 40 identified quality of care problems with their personal care services aide, problems with the personal care services agency, or other problems. These include, but are not limited to, physical abuse or threats of physical abuse, theft, engaging in unrelated activities, and abandonment.

RECOMMENDATIONS

We recommend that the State:

- refund \$275,327,274 to the Federal Government,
- work with CMS to resolve the two CDPAP claims,
- improve its monitoring of New York City's personal care services program to ensure compliance with Federal and State requirements, and
- promulgate specific regulations related to claims submitted under the CDPAP.

NEW YORK STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. The State also disagreed with many elements of our findings. The State indicated that the claims in our sample were “substantially in compliance” with Federal regulations and that DOH social services districts throughout the State strive to meet the State’s regulations. In addition, the State provided us with additional documentation for certain sample claims.

After reviewing the State’s comments on our draft report and additional documentation, we revised our findings and modified our statistical estimates accordingly. The State’s comments appear in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New York State's Medicaid Program

In New York State (the State), the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Medicaid Management administers the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care services claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From January 1, 2004, to June 30, 2004, the FMAP in the State was 52.95 percent, and from July 1, 2004 through December 31, 2006, the FMAP was 50 percent.

New York State's Personal Care Services Program

The State's personal care services program is operated by DOH's Bureau of Medicaid Long Term Care. Although DOH is responsible for the program, each county's social services district and New York City (comprising Bronx, Kings, New York, Queens, and Richmond counties) is responsible for authorizing personal care services, arranging service delivery, and monitoring the personal care services program. Title 18 § 505.14 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) defines personal care services as some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, and health-related tasks. Such services must be essential to the maintenance of the beneficiary's health and safety within his or her own home, as determined by the social services district in accordance with the regulations of DOH; ordered by the attending physician; based on an assessment of the beneficiary's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

The State operates two levels of personal care services:

- Level I services are limited to the performance of environmental and nutritional functions, including dusting, vacuuming, dishwashing, shopping, laundry, and meal preparation, and

- Level II services include Level I services and personal care functions such as assisting beneficiaries with bathing, grooming, and toileting.¹

New York City's Personal Care Services Program

In New York City, the Human Resources Administration (HRA) oversees the personal care services program. HRA provides case management through nine Community Alternative Services Agency offices. Services are provided through contracts with home care/personal care agencies.

To receive personal care services, a Medicaid beneficiary must have a physician's order. When HRA receives the physician's order, a case record is established and a case worker is assigned to the beneficiary. An initial authorization for services is based on the physician's order, a social assessment, and a nursing assessment. Authorizations for personal care services are required to be completed before the initiation of services. HRA authorizes all services for periods of up to 12 months, except 24-hour continuous care, which is authorized for only up to 6 months. The reauthorization process generally includes the same procedures as the initial authorization; however, Level I services do not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged. After completing the authorization process, an HRA case worker contacts a local personal care services provider so it can assign a personal care aide unless the beneficiary hires his or her own aide under the State's Consumer Directed Personal Assistance Program (CDPAP).²

Federal and State Requirements Related to Personal Care Services

The State and HRA must comply with certain Federal and State requirements in determining and redetermining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.

¹New York regulations reference three levels of service (Level I, Level II, and Level III), but the State's current personal care services program provides only Level I and Level II services.

²Section 365-f of the New York Social Services Law established CDPAP. Under CDPAP, the beneficiary may hire his or her own aide, train the aide according to the beneficiary's personal preferences, supervise and direct the provision of service, and fire the aide. Although the program has been in effect since 1996, it was not defined under the State plan until Amendment 07-32 was approved by CMS on April 8, 2008, with an effective date of July 1, 2007. The State plan notes that the eligibility, assessment, and prior authorization of services mirror those of the personal care services program. The State has not promulgated specific State regulations applicable to CDPAP.

Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A of the Circular provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

Title 18 of NYCRR § 505.14 establishes requirements for the State's personal care services program. These requirements include that a physician, physician's assistant, or nurse practitioner (medical professionals) complete the order for personal care services within 30 calendar days of conducting a medical examination and that social and nursing assessments be prepared as part of the authorization and reauthorization of personal care services. Authorization for Level I and II services must be based on an assessment of the beneficiary's appropriateness for other services that are medically necessary and that HRA "reasonably expects can maintain the patient's health and safety in his or her home . . ."³ Finally, persons providing Level I and II personal care services are subject to nursing supervision. Appendix A contains the specific Federal and State requirements related to personal care services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine if the State properly claimed Federal Medicaid reimbursement for personal care services claims submitted by 100 providers in New York City.

Scope

Our audit period covered January 1, 2004, through December 31, 2006. Our audit universe consisted of 42,660,297 claims, totaling \$4,962,396,539 (\$2,499,866,017 Federal share), submitted by the 100 New York City providers.

During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork at DOH's offices in Albany, New York; at the State MMIS fiscal agent in Rensselaer, New York; at HRA's offices in New York City; and at 53 personal care providers in New York City.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines;
- held discussions with DOH and HRA officials to gain an understanding of the personal care services program;

³Some examples of these services include long-term home health services and personal emergency response services.

- used providers' correspondence addresses and county codes on the MMIS, which identified 100 personal care providers in New York City;
- ran computer programming applications at the MMIS fiscal agent that identified 42,674,738 personal care services claims, totaling over \$4.9 billion (\$2.5 billion Federal share) for the 100 New York City providers;
- eliminated from our programming applications all New York City personal care services claims identified in an August 2007 Office of the New York State Comptroller audit report;⁴
- determined that our revised sampling frame contained 42,660,297 claims, totaling \$4,962,396,539 (\$2,499,866,017 Federal share), made by the 100 New York City providers;
- selected a simple random sample of 100 claims from the population of 42,660,297 claims, and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 42,660,297 claims.

Appendix B contains the details of our sample design and methodology.

For each of the 100 sampled claims, we:

- reviewed the corresponding personal care provider's documentation supporting the claim;
- reviewed the corresponding HRA case file;
- reviewed documentation from the physician ordering the personal care services to confirm whether a medical professional had examined the beneficiary within 30 days before the order was signed; and
- visited the beneficiary, if available, associated with the claim to inquire about the personal care services he or she received and referred all quality-of-care issues identified by the beneficiary to our Office of Investigations.⁵

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

⁴"Medicaid Payments to Home Care Providers While Recipients Were Hospitalized," Office of the New York State Comptroller, Division of State Government Accountability, Report 2006-S-77 (August 28, 2007).

⁵Due to various reasons (i.e., the beneficiaries were deceased, had moved out of the State, or could not be located), we were able to visit only 65 of the 100 beneficiaries.

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 objective.

FINDINGS AND RECOMMENDATIONS

The State improperly claimed Federal Medicaid reimbursement for some personal care services claims submitted by providers in New York City. Of the 100 claims in our random sample, 80 claims complied with Federal and State requirements, but 18 claims did not. We could not determine if the remaining two claims, which involved services under the State’s CDPAP program, complied with Federal and State requirements and are setting aside those claims for resolution by CMS and the State. Of the 18 claims, 1 contained more than one deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims⁶
Medical professional did not examine the beneficiary within 30 days before the order for personal care services was signed (medical record does not support examination date)	8
No nursing assessment	4
No nursing supervision	4
No physician’s order	3

For two sample claims submitted under the CDPAP program, there were no applicable nursing assessments. These two claims are being set aside for resolution by CMS and the State because it is unclear whether State requirements apply to these claims.

These deficiencies occurred because the State did not adequately monitor New York City’s personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimate that the State improperly claimed \$275,327,274 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period.

⁶The total exceeds 18 because 1 claim contained more than one error.

MEDICAL PROFESSIONAL DID NOT EXAMINE THE BENEFICIARY WITHIN 30 DAYS BEFORE THE ORDER FOR SERVICES WAS SIGNED (MEDICAL RECORD DOES NOT SUPPORT EXAMINATION DATE)

Pursuant to 18 NYCRR § 505.14(b)(3)(i), a medical professional is required to complete the physician's order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary. For 8 of the 100 claims in our sample, the required medical professional did not examine the beneficiary within 30 calendar days before the physician's order was signed.⁷

NO NURSING ASSESSMENT

Pursuant to 18 NYCRR § 505.14, authorizations for Level I and II services must include a nursing assessment prepared by a registered professional nurse.⁸ For 4 of the 100 claims in our sample, HRA could not provide an applicable nursing assessment.

NO NURSING SUPERVISION

Pursuant to 18 NYCRR § 505.14(f), all persons providing Level I and II personal care services are subject to supervision by a registered nurse. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change.⁹ In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months. For 4 of the 100 claims in our sample, there was no evidence that a registered nurse supervised the personal care services within the 6 months before the date of the sample service.¹⁰

NO PHYSICIAN'S ORDER

Pursuant to section 1905(a)(24) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 18 NYCRR § 505.14, personal care services must be authorized by a physician. The physician's order is part of an authorization package that must be completed before the authorization and reauthorization of services. Of the 100 claims in our sample, 3 did not have an applicable physician's order before the authorization or reauthorization period of personal care services.

⁷Although a medical examination date was noted on the physician's order, we based our disallowances for this category on the fact that the underlying medical record for each claim did not support the examination date.

⁸Reauthorization for Level I services does not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged.

⁹Self-directing means that the beneficiary is capable of making choices about his or her activities of daily living, understanding the impact of the choice, and assuming responsibility for the results of the choice.

¹⁰All four claims involved Level I services. HRA is responsible for the performance of nursing supervision for these services.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM CLAIMS

New York Social Services Law 365-f established CDPAP in 1996. The State has not issued specific regulations applicable to the CDPAP. Of the 100 claims in our sample, 2 were CDPAP claims for which there were no applicable nursing assessments. We are setting aside these claims because it is unclear whether State requirements regarding nursing assessments (18 NYCRR § 505.14) apply to CDPAP claims.

CAUSE OF UNALLOWABLE CLAIMS

The State did not adequately monitor New York City's personal care services program for compliance with certain Federal and State requirements. The State conducts periodic onsite monitoring visits of its local social services districts to review case records for compliance with applicable State regulations. However, during our audit period, the State did not conduct any monitoring visits of New York City's personal care services program, which accounts for over 80 percent of the costs of the State's personal care services program.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 100 personal care services claims sampled, 18 were not made in accordance with Federal and State requirements. Based on our sample results, we estimate that the State improperly claimed between \$275,327,274 and \$625,112,147 in Federal Medicaid reimbursement from January 1, 2004, through December 31, 2006. If CMS determines that the 2 set-aside claims are unallowable, we will add the unallowable amounts for these 2 claims to the 18 questioned claims and will revise the estimate of the 20 sample error claims. The details of our sample results and estimates are shown in Appendix C.

RECOMMENDATIONS

We recommend that the State:

- refund \$275,327,274 to the Federal Government,
- work with CMS to resolve the two CDPAP claims,
- improve its monitoring of New York City's personal care services program to ensure compliance with Federal and State requirements, and
- promulgate specific regulations related to claims submitted under the CDPAP.

NEW YORK STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. The State also disagreed with many elements of our findings. The State indicated that the claims in our sample were

“substantially in compliance” with Federal regulations and that DOH social services districts throughout the State strive to meet the State’s regulations. In addition, the State provided us with additional documentation for certain sample claims.

After reviewing the State’s comments on our draft report and additional documentation, we revised our findings and modified our statistical estimates accordingly. The State’s comments appear in their entirety as Appendix D.

Medical Professional Did Not Examine the Beneficiary Within 30 Days Before the Order for Personal Care Was Signed

State Comments

The State indicated that HRA files contained physician orders for most sample claims that we indicated lacked physician orders signed 30 days before the orders for personal care were signed. In addition, the State indicated that HRA’s physician orders capture the dates a beneficiary visited the physicians and the dates of the physicians’ signatures. The State noted that it relies on the examination date appearing on the order. The State further indicated that the deficiencies we identified were based on unsuccessful attempts at obtaining an oral or written confirmation from the ordering physician that a physical examination occurred on the date indicated on the physician order form.

Office of Inspector General Response

We found dated orders for personal care for the eight beneficiaries in this category. The beneficiary examination dates indicated on these forms was fewer than 30 days before the dates of the orders for 7 of the 8 claims and greater than 30 days for 1 claim. Although medical examination dates were noted on the physicians’ orders, we disallowed claims when the underlying medical records for the claims did not support the examination dates. We determined that a sample claim was improper if the beneficiary’s medical records showed that the medical examination had not occurred within 60 calendar days before the date the physician’s order was signed. We maintain that 8 of the 100 claims in our sample were unallowable because medical professionals did not examine the beneficiaries within 30 calendar days before the physicians’ orders were signed. Our determination for each of these claims was based on a review of the beneficiaries’ medical records—not on unsuccessful attempts at obtaining written or oral confirmation from the ordering physicians.

No Nursing Assessment

State Comments

The State indicated that, for one sample claim, the beneficiary’s condition was unchanged and, therefore, the beneficiary did not need another nursing assessment. For a second sample claim, the State indicated that the case was “open to” New York City’s adult protective services program and not managed by HRA.

Office of Inspector General Response

The first sample claim was a Level II case, and Level II cases require a nursing assessment for reauthorization of services. Regarding the second sample claim, New York City's adult protective services program is a unit within HRA. Therefore, the program is required to follow the same regulations as HRA's personal care program. We maintain that 4 of the 100 claims in our sample were unallowable because HRA could not provide applicable nursing assessments.

No Nursing Supervision

State Comments

The State indicated that it previously advised us that its nursing supervision requirements were inadvertently omitted from HRA's 2003 contracts for Level I personal care services. The State indicated that it revised its Level I contractor applications after being notified of this omission in 2006; however, the nursing supervision requirements were not implemented until 2008. The State did not dispute that the four claims in the category were in error.

No Physician's Order

State Comments

The State indicated that two of the three sample claims identified as lacking physicians' orders are "open to" New York City's adult protective services program and not managed by HRA. In addition, the State indicated that original physicians' orders for the associated beneficiaries identified chronic medical conditions requiring ongoing care to remain at home. The State also indicated that, in accordance with Federal fair hearing requirements, HRA cannot discontinue services on the basis of not having received a new physician's order without first providing timely and adequate notice to the beneficiary.

Office of Inspector General Response

New York City's adult protective services program is a unit within HRA. Therefore, the program is required to follow the same regulations as HRA's personal care program. We maintain that 3 of the 100 claims in our sample were unallowable because physicians' orders were not provided.

**OTHER MATTER: BENEFICIARY-IDENTIFIED PROBLEMS
WITH PERSONAL CARE SERVICES**

We interviewed 65 of the 100 sampled beneficiaries to determine whether quality-of-care issues existed, the service type and frequency, and whether any service-related problems existed. We did not interview the remaining 35 sampled beneficiaries because the beneficiaries were deceased, had moved out of the State, or could not be located. Of the 65 beneficiaries interviewed, 40 identified quality-of-care problems with their personal care services aide, problems with the personal care services agency, or other problems.¹¹ Table 2 summarizes the problems identified and the number of beneficiaries who encountered each type of problem.¹²

Table 2: Problems Identified in Beneficiary Interviews

Type of Problem	Number of Beneficiaries ¹³
Personal care aide engaged in unrelated activities	25
Plan of care not followed by the personal care aide	19
Problems with the personal care agency	14
Theft of property by the personal care aide	9
Beneficiary did not receive a plan of care	9
Physical abuse/threats by the personal care aide	7
Beneficiary abandonment by the personal care aide	3
Other	16

Below are examples of some of the problems identified in our interviews.

PERSONAL CARE AIDE ENGAGED IN UNRELATED ACTIVITIES

Of the 65 beneficiaries we interviewed, 25 indicated that a personal care services aide engaged in activities unrelated to beneficiary care while on duty. For example, beneficiaries indicated that, during duty hours, aides would sleep, disappear for excessive periods of time, talk on their cell phones, show up briefly before leaving, or leave to shop for themselves. One beneficiary stated an aide left 2.5 hours early and forged the beneficiary’s signature on the timesheet.

THEFT OF PROPERTY

Of the 65 beneficiaries we interviewed, 9 indicated that a personal care services aide stole property from them. Among items allegedly stolen were a silver-covered Bible, kitchen utensils,

¹¹We were unable to determine if any of the identified problems occurred on the specific service date drawn in our sample. For some beneficiaries, we were able to determine that the problems identified occurred during our audit period or that the aide on duty on the service date we reviewed was the cause of the beneficiary’s problems. Not all of the identified problems occurred during our 3-year audit period.

¹²We referred all quality-of-care issues identified by the 40 beneficiaries to our Office of Investigations.

¹³The total exceeds 40 because 25 beneficiaries identified more than one problem.

gold and silver coins, a ring valued at \$300, a \$250 money order, and cash. One beneficiary indicated that she filed a police report alleging that an aide stole a diamond necklace and a ring.

PHYSICAL ABUSE OR THREATS OF PHYSICAL ABUSE

Of the 65 beneficiaries we interviewed, 7 indicated that a personal care services aide abused or threatened to abuse them. For example, one beneficiary indicated that she was robbed by an aide who had threatened her with a knife.¹⁴ She further indicated that some aides would “get rough” with her by pinching her after she would fall or trip. A second beneficiary indicated that she filed a complaint against an aide for abusive language. According to the beneficiary, after filing the complaint, both the aide and the aide’s supervisor visited the beneficiary in her home, cornered her, and tried to intimidate her into backing down from the complaint. Other examples of abuse alleged by beneficiaries included an aide biting a beneficiary’s finger and physical retaliation by an aide against a beneficiary who filed a complaint.

BENEFICIARY ABANDONMENT

Of the 65 beneficiaries we interviewed, 3 indicated that a personal care services aide abandoned them. One indicated that her aide abandoned her on two occasions—in the street and in the subway—because the aide’s shift had ended and the aide wanted to go home. A second beneficiary indicated that her aide abandoned her in a large retail store, and a third beneficiary indicated that her aide left her unattended at home.

¹⁴The beneficiary indicated that the aide did not physically display a knife.

APPENDIXES

**FEDERAL AND STATE REQUIREMENTS RELATED TO
PERSONAL CARE SERVICES**

- Section 1905(a)(24) of the Social Security Act and implementing Federal regulations (42 CFR § 440.167) permit States to elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician within a plan of treatment or in accordance with a service plan approved by a State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.
- Federal regulations (42 CFR § 440.167(a)(1)) and Title 18 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) § 505.14 specify that personal care services must be authorized by a physician. The physician's order is part of an authorization package that is required to be completed before the initial authorization and reauthorization of services.
- Office of Management and Budget Circular A-87 establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A of the Circular provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.
- Medical professionals must complete the physician's order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary (18 NYCRR § 505.14(b)(3)(i)). A physician must sign the physician's order and certify that the recipient can be cared for at home.
- All persons providing Level I and II personal care services must be subject to nursing supervision (18 NYCRR § 505.14(f)). This supervision must ensure that the beneficiary's needs are appropriately met by the case management agency's (Human Resources Administration) authorization for the level, amount, frequency, and duration of services and that the person providing services is competent and safely performing the tasks specified in the plan of care. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change. In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months.
- The initial authorization for Level I and II services must include a nursing assessment prepared by a registered professional nurse (18 NYCRR § 505.14(b)(2)(iii)). Reauthorization for Level I services does not require a nursing assessment if the physician's order indicates that the beneficiary's medical condition is unchanged (18 NYCRR § 505.14(b)(3)(ix)(a)). The nursing assessment shall include the following: (1) a review and interpretation of the physician's order, (2) the primary diagnosis code, (3) an evaluation of the functions and tasks required by the beneficiary, (4) the degree of assistance required, (5) the development of a plan of care, and (6) recommendations for authorization of services (18 NYCRR § 505.14(b)(3)(iii)(b)).

SAMPLE DESIGN AND METHODOLOGY

Population

The population was personal care services claim lines submitted by 100 providers in New York City during our January 1, 2004, through December 31, 2006, audit period that were claimed for Federal Medicaid reimbursement by the State.

Sampling Frame

The sampling frame was a computer file containing 42,660,297 detailed claim lines for personal care services submitted by 100 providers in New York City during our audit period. The total Medicaid reimbursement for the 42,660,297 claim lines was \$4,962,396,539 (\$2,499,866,017 Federal share). The Medicaid claim lines were extracted from the paid claims' files maintained at the Medicaid Management Information System fiscal agent.

Sampling Unit

The sampling unit was an individual Federal Medicaid claim line.

Sample Design

We used a simple random sample to evaluate the population of Federal Medicaid claim lines.

Sample Size

We selected a sample size of 100 claim lines.

Source of Random Numbers

The source of the random numbers was the Office of Inspector General, Office of Audit Services, statistical software, RAT-STATS. We used its random number generator for selecting our random sample items.

Method for Selecting Sample Items

We sequentially numbered the 42,660,297 detailed claim lines. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

Estimation Methodology

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the improper claiming.

SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
42,660,297	\$2,499,866,017	100	\$6,231	18	\$1,055

Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Unallowable Costs
Point Estimate	\$450,219,710
Lower Limit	\$275,327,274
Upper Limit	\$625,112,147

DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

February 10, 2009

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-07-01054

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-07-01054 on "Review of Medicaid Personal Care Services Claims Made by Providers in New York City."

Thank you for the opportunity to comment.

Sincerely,



Wendy E. Saunders
Executive Deputy Commissioner

Enclosure

cc: Robert W. Reed
Mark L. Kissinger
Deborah Bachrach
James Sheehan
Carla Williams
Stephen Abbott
Nicholas Meister
Irene Myron
Ronald Farrell
Gail Kerker

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-07-01054 on
“Review of Medicaid Personal Care Services Claims
Made by Providers in New York City”**

The Department of Health and Human Services, Office of Inspector General (the “OIG”) recently completed a “Review of Medicaid Personal Care Service Claims Made by Providers in New York City” and issued a draft report dated September 2008 (the “Report”). The New York State Department of Health (the “DOH”) has reviewed the Report and selected OIG workpapers. In addition, the DOH has consulted with the New York City Human Resources Administration (“HRA”) and reviewed their files and supporting documentation with respect to this matter. The DOH has detailed herein the results of its review of the Report’s specific findings and recommendations.

BACKGROUND

General

New York State’s Personal Care Services Program (the “PCSP”) was established in 1973 and is one of the oldest and largest in the country. Regulations were developed when the program largely served elderly women living alone who had some informal supports and who had occasional need for assistance with the activities of daily living. As a result of federal initiatives and incentives to rebalance states’ long term care systems, individuals formerly cared for in institutional settings are now served in their homes and community. Today’s PCSP population includes mentally and physically disabled children and younger adults and elderly with co-morbidities whose health and safety are dependent upon the availability of personal care services. New York State has long been nationally recognized as a leader in the development of innovative long term care programs and services which allow individuals to remain in their homes and communities.

In Olmstead v. L.C., 527 U.S. 581 (1999), the United States Supreme Court held that the Americans with Disabilities Act requires States to place disabled patients in integrated settings (that is, in community settings) when they are medically cleared for such settings. The Court held that “the State generally may rely upon the reasonable assessments of its own professionals in determining whether an individual meets the essential eligibility requirements. . .” (for placement in a community-based treatment setting).

In response to the Supreme Court’s issuance of the Olmstead Decision, CMS directed states to take necessary measures to assure that beneficiaries are provided the opportunity to receive services in the least restrictive setting appropriate to their needs. Since that directive was issued, New York State has partnered with CMS on several grant initiatives to promote home and community-based care and delay/prevent unnecessary institutionalization of individuals with disabilities. PCSP is a critical

component of New York State's home care system assuring the least restrictive setting to the beneficiary and lowest cost to the system. In working with CMS on these issues, New York has, as Olmstead states, relied upon the reasonable assessments of its licensed, Medicaid participating, physicians to determine the need for provision and continuation of these services.

Regulations

Federal regulations (42CFR 440.167) require that personal care services be furnished to beneficiaries who are not an inpatient or resident of a hospital, nursing facility or intermediate care facility for the mentally retarded, or institution for mental disease. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State. New York State regulations require:

- personal care services must be authorized and reauthorized based on a physician's order, nursing assessment, and social assessment;
- a physician, physician's assistant, or nurse practitioner (medical professionals) must examine the beneficiary within 30 days before the physician's order is signed;
- the delivery of personal care services must be supervised by a registered professional nurse; and,
- an initial hospice assessment must be performed before claiming Medicaid reimbursement.

Title 18 § 505.14 of New York State Compilation of Codes, Rules & Regulations defines personal care services as some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support, and health and safety within his or her own home, as determined by the social services district in accordance with the regulations of DOH; ordered by the attending physician; based on an assessment of the beneficiary's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

HRA Process

A standard verification protocol is initiated when HRA's Central Intake or satellite office receives a physician's order for personal care services. The process includes verification of the physician's name and license number on the web-based State physician registry (<http://www.op.nysed.gov/opsearches.htm#nme>) and the Medicaid eligibility of the beneficiary's name on the physician order. Further, the date of the physician's examination is checked against the physician signature date to ensure completion within the 30 day period as required by regulation. If the documentation is incomplete or the dates are not compliant, the order is returned to the physician for resolution of the problem.

HRA has several established mechanisms for monitoring and assuring physician integrity, including: tracking personal care services orders by physician name and frequency and cross-referencing them with recipient addresses; maintenance of a home care complaint hotline; investigating/auditing suspicious/inappropriate conduct; and

aggressively prosecuting confirmed violators. In addition, the New York State Office's of the Medicaid Inspector General (the "OMIG"), Attorney General and State Comptroller, complement local physician order compliance efforts through discrete program audits, claim processing reviews and, when appropriate, prosecution and/or recoupment actions. The OMIG recently released draft regulations designed to help assure provider compliance with Medicaid requirements. To further assure Medicaid program integrity and prevent inadvertent fraudulent behaviors, the DOH maintains an electronic library of Medicaid provider manuals, including one for physicians. In addition to provider claiming instructions, each manual contains a General Medicaid Program Information Section, inclusive of information on unacceptable practices which may be subject to prosecution and/or expulsion from participation in the program. These include *ordering* or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies. The manuals, which are available online, reference the supporting New York State regulations (18NYCRR, Parts 515, 516, 517 and 518) which permit the DOH to impose monetary penalties on, or sanction and recover overpayments from, providers or *prescribers* of medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition.

The DOH recognizes that regulatory compliance is an important *evaluation* factor in program audits.

OIG DRAFT REPORT

The OIG audit focused on personal care services claims submitted by one hundred (100) providers in the New York City area for the three years ended December 31, 2006. The OIG sampled one hundred (100) randomly selected claims from a universe of 42,660,297 claims. Of the 100 sample selection, 60 were determined by OIG to be in compliance with documentation and billing regulation. The OIG has, on a preliminary basis, identified 38 claims which it believes to be in error and 2 claims requiring further analysis. Summarized below are the numbers of claims, by type, the OIG believes to be in error:

MEDICAL PROFESSIONAL DID NOT EXAMINE THE BENEFICIARY WITHIN 30 DAYS BEFORE THE ORDER FOR PERSONAL CARE SERVICES WAS SIGNED	19
NO SOCIAL ASSESSMENT	14
NO NURSING ASSESSMENT	6
NO NURSING SUPERVISION	4
NO PHYSICIAN'S ORDER	3
NO HOSPICE ASSESSMENT	1
TOTAL	38

Based on the above, the OIG contends that New York State was overpaid approximately \$815,000,000, federal share only.

The DOH and HRA have reviewed the Federal and New York State regulations governing personal care services, read the OIG underlying work papers with respect to the issues, inspected HRA documentation and interviewed HRA operational personnel. The DOH and HRA undertook this effort to better understand the issues and to ascertain the propriety of the OIG findings in the Report. Summarized below are the results of this review.

MEDICAL PROFESSIONAL DID NOT EXAMINE THE BENEFICIARY WITHIN 30 DAYS BEFORE THE ORDER FOR PERSONAL CARE SERVICES WAS SIGNED

OIG Findings:

“Pursuant to 18 NYCRR § 505.14(b)(3)(i), a medical professional is required to complete the physician’s order for personal care services within 30 calendar days after conducting a medical examination of the beneficiary. For 19 of the claims in our sample, the required medical professional did not examine the beneficiary within 30 calendar days before the physician’s order was signed.”

DOH Response:

The DOH determined that HRA files contain physician orders for seventeen (17) of the nineteen (19) claims the OIG indicated lacked physician orders signed within 30 days of that date as required by DOH regulation. The physician orders used by HRA capture the date of the visit to the physician and the date of the physician’s signature. The DOH understands that the physician order deficiencies identified by the OIG are based on the OIG’s unsuccessful attempt at obtaining a verbal or written confirmation from the ordering physician that a physical examination occurred on the date indicated on the physician order form. Further, the OIG concluded that, absent a confirming physician response, these physician orders are invalid.

It is common healthcare industry practice for health care providers to rely on the accuracy of signed and dated physician orders. It would be impractical and costly for healthcare providers to routinely verify the accuracy of physician orders with the physician before services are rendered to eligible beneficiaries. The DOH review of Federal and State laws, rules and regulations did not identify any requirement for a provider to routinely verify signed and dated physician orders before services are rendered.

The DOH can not address the physicians’ failure to respond to an OIG informational request with respect to this matter. The DOH contends that the OIG position in this matter is not supported by law, rules or regulation as sufficient bases to conclude that a physical examination did not occur on the date identified on the signed physician order and that the order is therefore invalid.

The OIG findings suggest that HRA should review physician claims to confirm that the physician’s order is based on a same day examination office visit *before* services are

prior authorized. This is not practical as physician claims can be submitted to the state's eMedNY claim processing system months after the actual service was provided. Nor is it feasible to contact each physician by electronic means or by on-site visit to verify that each and every physician's order received by HRA is based on a same day physical as indicated by the ordering physician. In addition to being administratively cumbersome and cost-prohibitive, completion of such onerous requirements would delay provision of immediately needed services. Hospital and nursing home patients whose discharge plan is dependent on the availability of home care services would have to remain institutionalized pending confirmation activities. Beneficiaries already living in the community, but whose health and safety is at risk absent services, may be faced with costly, disruptive and unnecessary institutionalization pending validation of the physician's order. Physicians are state-licensed medical professionals, obligated to practice in accordance with accepted standards of conduct. Health insurance programs, including Medicaid and Medicare, that require a physician's order based on current patient status, rely on such standards of practice and accept physician orders for services and equipment in good faith. The DOH would be amenable to reviewing any other states' pre-service physician order verification system that the OIG is aware of for potential application in New York State.

The mechanisms employed by the DOH and HRA to assure compliance with Federal and State physician order requirements are more cost-effective and more appropriately assure the timely provision of services to eligible beneficiaries in need of home care services.

NO SOCIAL ASSESSMENT

OIG Findings:

"Pursuant to 18 NYCRR § 505.14 authorizations and reauthorizations of personal care services require a social assessment. Of the 100 claims in our sample, 14 records did not contain an applicable social assessment."

DOH Response:

The DOH determined social assessment documentation supporting 5 of the cases is available. For 2 of the 5 cases the record supports that, because of the case circumstances, a social assessment was completed by other appropriate professional staff and then reviewed and accepted by the HRA caseworker. In 1 case, a written case note pertaining to a home visit by a New York City Adult and Children Services (ACS) Protective Services caseworker adequately addresses the purpose of the social assessment criteria set forth in 18NYCRR § 505.14(b)(3)(ii). The other situation involves an open under-care case where the beneficiary was hospitalized. The hospital social worker provided HRA with written documentation attesting to an increased need for services upon hospital discharge *as a result of a change in the beneficiary's medical condition*. The HRA case manager reviewed the documentation and entered it into the case record. Case notes support that the case manager's review and concurrence of documentation pertaining to the beneficiaries social circumstances met the objective of required assessment criteria cited in 18NYCRR § 505.14 (f)(3)(iv)(c)(1).

Of the remaining 9 cases, seven are clearly individuals who would be at extreme risk of hospitalization or institutionalization if personal care services were discontinued pending completion of a social reassessment. Four of the individuals are 90 years of age or older, some require total assistance in *all* activities of daily living and some suffer from varying degrees of dementia. These are all under-care cases whose social situation had not changed as supported by nursing supervision visit reports contained in the case record. Part of the nursing supervisor's role, per §505.14(f)(3)(c)(1), is to contact the local district case manager when any change in the social or medical condition is observed by the aide or the nurse supervisor. This requirement serves as a patient quality of care mechanism and also provides checks and balances to reassessment requirements. The absence of such nursing supervisory contact being made to HRA affirms the beneficiary's unchanged medical, mental or social condition and the continued need for currently authorized services.

NO NURSING ASSESSMENT

OIG Findings:

"Pursuant to 18 NYCRR § 505.14, authorizations for Level I and II services must include a nursing assessment prepared by a registered professional nurse. For 6 of the 100 claims in our sample, HRA could not provide an applicable nursing assessment."

DOH Response:

The DOH located Nursing assessments for two of the cases. In another case the beneficiary did receive a nursing assessment visit within the authorization period covering the claim date identified by OIG. In the latter case, there was no change in the beneficiary's condition necessitating another nursing assessment, and the case assessment documentation is in regulatory compliance. One case is open to ACS Protective Services and therefore is not a case managed by HRA. HRA and ACS have been working to refine protocols to assure Medicaid requirements are met on joint cases in which primary case management rests with ACS.

NO NURSING SUPERVISION

OIG Findings:

"Pursuant to 18 NYCRR § 505.14(f), all persons providing Level I and II personal care services are subject to supervision by a registered nurse. Supervisory nursing visits must be made at least every 90 days except when the beneficiary is self-directing and his or her medical condition is not expected to change. In those cases, supervisory and nursing assessment visits may be combined and conducted every 6 months. For 4 of the 100 claims in our sample, there was no evidence that a registered nurse supervised the personal care services within the 6 months before the date of the sample service."

DOH Response:

HRA previously advised OIG that the nursing supervision requirements were inadvertently omitted from the 2003 HRA Level I contracts. Prior to that time, nursing supervision was a contract requirement for all levels of personal care services. When the omission was brought to HRA's attention in 2006, corrective action was taken although because of local law requirements governing contract agreements and challenges to a revised request for Level I contractor applications, implementation of the re-activated nursing supervision requirements for Level I cases occurred in 2008. HRA made diligent efforts to comply with the programmatic regulations once the oversight was identified.

NO PHYSICIAN'S ORDER**OIG Findings:**

"Pursuant to § 1905(a)(24) of the Act, implementing Federal regulations (42 CFR §440.167(a)(1)), and 18 NYCRR § 505.14, personal care services must be authorized by a physician. The physician's order is part of an authorization package that must be completed before the authorization and reauthorization of services. Of the 100 claims in our sample, 3 did not have an applicable physician's order before the authorization or reauthorization period of personal care services."

DOH Response:

The DOH determined that two cases are open to ACS Protective Services and, therefore, are not cases managed by HRA. Additionally, these are clearly under-care cases in which the original physician's order identifies that the beneficiary has chronic medical conditions requiring on-going care in order to remain at home. One case is a 78 year old with cognitive impairment. The other case is a 77 year old with multiple comorbidities including end stage renal disease. The continued medical necessity for services is indisputable, and because of health and safety issues, in neither case could services be discontinued despite the absence of a current physician's order. In accordance with federal fair hearing requirements, HRA cannot discontinue services on the basis of not having received a new physician's order without first providing timely and adequate notice to the beneficiary and affording the beneficiary continuing aid pending the outcome of the fair hearing.

NO HOSPICE ASSESSMENT**OIG Findings:**

"Pursuant to 18 NYCRR § 505.14(b)(2)(v), initial authorization for Level I and II services must be based on an assessment of the beneficiary's appropriateness for hospice services. For 1 of the 100 claims in our sample, there was no evidence that an initial hospice assessment was performed."

DOH Response:

A patient's participation in hospice is voluntary and not all terminally ill patients need or want hospice services. Physicians generally discuss this care option with the beneficiary and/or his/her family and, if desired, a referral for an assessment for hospice services is ordered by the physician. The physician did not order a hospice assessment, but instead identified to the local district that he/she felt that the patient's needs could be met with the provision of personal care services. The social and nursing assessments affirmed the physician's determination that personal care services could appropriately meet the beneficiary's needs. As neither the State nor the local district can require terminally ill patients to be assessed for, or receive, hospice services, this case should not be considered deficient.

GENERAL COMMENTS ON DRAFT OIG FINDINGS

The DOH believes the subject claims are substantially in compliance with the federal regulations. The audit deficiencies are based on a review of isolated portions of the PCSP regulations as opposed to the totality of the intent of the regulations. The State's regulations are comprehensive and detailed, and contain numerous standards and requirements which the state and local districts diligently strive to achieve. They also contain many procedural checks and balances to assure appropriate services are provided to qualified individuals when circumstances preclude strict adherence to procedural standards set forth in the regulations. When a Medicaid beneficiary has an immediate need for services in order to remain in his or her home, a local district may have to choose between strict regulatory procedural compliance or patient health and safety. The DOH hopes in such situations that the Centers for Medicaid and Medicare Services (CMS) would prioritize patient health and safety over procedural compliance. If the OIG asserts that strict adherence to procedural requirements contained in the State's regulations is the essential criteria upon which FFP is based, New York and other states may be forced to re-evaluate their home and community-based program/services regulations.

REVIEW OF OIG RECOMMENDATIONS

Detailed below for the OIG's review and consideration is the DOH's response to each recommendation.

Recommendation #1:

The State should refund \$814,759,296 to the Federal Government.

DOH Response:

OIG's draft report indicated that 38 of the 100 claims in their audit sample did not comply with Federal and State requirements, with the 38 claims containing 47 deficiencies, and that, as a result, the State improperly claimed \$814,759,296 in Federal Medicaid reimbursement.

The OIG's estimated overpayment amount is predicated on 38 sample selection errors. The DOH requested the OIG's underlying workpapers supporting questioned claims in order to ascertain the propriety of the questioned claims. The DOH was able to gather additional documentation that if inspected by OIG would have a material impact, if not eliminate, the estimated overpayment. DOH is prepared to provide OIG this additional documentation in an effort to resolve this matter.

Recommendation #2:

The State should work with CMS to resolve the two Consumer Directed Personal Assistance Program (CDPAP) claims.

DOH Response:

The DOH is available to work with CMS on any issues of concern related to the two CDPAP claims reviewed by the OIG.

Recommendation #3:

The State should improve its monitoring of New York City's Personal Care Services Program to ensure compliance with Federal and State requirements.

DOH Response:

The DOH has implemented significant improvements in monitoring the local districts' administration of PCSP since the time period covered by this audit. In 2007, the DOH established the Office of Long Term Care (OLTC) and within that office, the Division of Home and Community-Based Services. The allocation of additional staffing resources have allowed for increased on-site record review of local district case records, monitoring of local administrative protocols and feedback to local districts in the form of a PCSP Monitoring Report. As needed, local districts are required to submit Corrective Action Plans for cited deficiencies.

Case record information is currently collected electronically by DOH staff and downloaded into a central database. The database provides DOH with a statewide view of current PCSP beneficiary demographics including, but not limited to, beneficiaries' functional abilities, primary diagnoses and correlating service authorizations. Identified trends and issues are used to evaluate current program requirements and to support future policy and program planning. DOH staff's increased local district presence has afforded greater opportunity to provide existing and newly hired local district staff with technical assistance and best practices information.

Besides on-site case record reviews, the DOH annually collects information related to each district's administration of PCSP. A standardized data collection form is forwarded electronically to each district for completion. The information collected tracks local district arrangements/contracts for social and nursing assessment completion and gathers information on issues/obstacles impacting service availability in that district (e.g., aide shortages). The individual district information is consolidated into a state-wide database and utilized for tracking local, regional and state-wide trends.

The DOH works collaboratively with HRA to improve administration of PCSP in New York City. Conversion of the State's Medicaid claims processing system from MMIS to eMedNY in 2005 served as a catalyst for HRA, using only New York City funding, to develop a local system capable of on-line interaction with eMedNY. This new web-based system, which will provide comprehensive internal controls for HRA's program administration, is expected to be introduced to HRA case managers early this year. The new system will assure case record compliance with required personal care services authorization/reauthorization protocols. The repository of the system will contain all documents related to the case record and will manage case record documentation by: providing mandatory supervisory review and sign-off on service authorizations; tracking the currency and timeliness of physician's orders, nursing and social assessments and service authorizations; and allowing for on-line entry of case management notes.

In addition, the DOH has advised the local districts of program policy and regulatory changes via the issuance of Administrative Directives, Local Commissioner's Memorandum, Medicaid Update publications and General Information System releases. DOH and local district staff attrition, exacerbated by growing retirements, is eroding the PCSP knowledge base. To help assure that local districts have ready access to current PCSP policies, the DOH has developed a training and reference manual for local districts which it expects to distribute this year. This manual will provide the local districts a cross-walk between regulatory requirements and state-issued administrative protocols and will aid in assuring uniform and equal treatment of beneficiaries across the state.

Recommendation #4:

The State should promulgate specific regulations related to claims submitted under the CDPAP.

DOH Response:

The DOH agrees and has drafted specific regulations for CDPAP which it expects to release for public comment during the early part of this year. Previously, promulgation of discrete regulations was delayed pending release of federal guidance on state plan option consumer directed programs.

OIG QUALITY OF CARE ISSUES

OIG indicates that it interviewed 65 of the 100 beneficiaries included in the audit sample and found 40 quality of care concerns which were referred to its Office of Investigations for follow-up. DOH requested OIG to furnish detailed information identifying these concerns for DOH follow-up. OIG responded by providing only a listing of the beneficiaries' names, claiming confidentiality issues prevented the release of further data. Quality of care is DOH's priority. The ability for DOH and HRA to follow up fully on these issues is of significant concern. DOH therefore respectfully requests the OIG to furnish a complete copy of its file documentation with respect to this matter.

Quality assurance is a vital and essential component of New York's Medicaid home care system. Multiple mechanisms exist at the State and local level to assure that

consumers receive appropriate services from qualified providers. When these standards are not met, consumers have access to multiple reporting systems that collaborate as needed, to assure quality of care and consumer protection.

State Quality Assurance Processes

The State enacted Chapter 959 of the Laws of 1984 requiring DOH's licensure of home care services agencies providing nursing, home health or personal care services. Pursuant to this legislation, DOH issued regulations (Title 10, Part 766) regarding operating requirements for licensed home care services agencies. The intent of the licensure regulations was to hold the agencies responsible for the quality and appropriateness of the care provided, whether provided directly or through a contractual arrangement. The licensure regulations and DOH policy memorandums subsequently issued identified home care agency operating requirements including comprehensive personnel requirements of individuals providing personal care services. Such requirements have been expanded over time and include, but are not limited to:

- criminal background check requirements for employees of direct care;
- employee health requirements;
- aide training requirements, including basic training, in-service training, on-the job training and overall job performance;
- supervision requirements; and,
- personnel record documentation requirements.

DOH conducts a pre-opening survey prior to issuance of an agency's home care agency license, and surveys for licensure compliance periodically thereafter. Identified deficiencies must be satisfactorily addressed within a specified time period as a condition of continued licensure approval.

DOH also maintains its own toll-free home care consumer hotline, with complaints investigated by DOH staff located in regional offices throughout the state. On initial home visits, agencies provide beneficiaries with patient rights information which includes the telephone number of the consumer hotline. DOH staff also investigates and respond to verbal and written complaints received from beneficiaries, advocates and other stakeholders. In 2008 legislation was enacted which directs DOH to establish a home care worker registry within twelve months, allowing consumers and home care agencies access to a listing of individuals qualified to provide personal care aide and home health aide services in New York State.

The State Office of the Attorney General also operates a Healthcare Bureau that protects and advocates for the rights of healthcare consumers statewide. The Bureau operates a toll-free helpline and collaborates with DOH as necessary on consumer complaints received.

Local Quality Assurance Processes

HRA maintains its own Complaint Tracking and Quality Control Unit, Home Attendant/Personal Care Aide Registry and Automated Attendance System. These measures were specifically created by HRA to:

- advise all personal care clients of their rights concerning registration, investigation and resolution of complaints concerning services provided by personal care services aides/home attendants;
- verify that services are being rendered in accordance with the care plan through random, unannounced visits by HRA staff;
- ensure that personal care aides/home attendants are properly qualified; and,
- assure the personal care aide's presence in the beneficiary's home during authorized hours through use of a telephone activated-timekeeper system.

The telephone number for HRA's home care complaint hotline is provided to every PCSP beneficiary initially authorized for services and redistributed to under-care beneficiaries annually thereafter. HRA has reviewed the cases included in the OIG sample against its Complaint Tracking and Quality Control database and found that only four recipients had lodged a complaint during the audit period and that all complaints had been investigated and resolved. Review of HRA data for the audit period identified that when interviewed during home visits, 99 percent of beneficiaries rated the services provided as good to excellent. In addition, HRA's Complaint Tracking Unit maintains detailed annual reports which identify the number of complaints, the level of severity and the number/percentage substantiated. Similarly, its Quality Control Unit documents the percentage of home care beneficiaries that receive unannounced home visits. A full statistical report for this activity is available.

Additionally, HRA reviews and evaluates contract providers' administrative responses to serious-substantiated complaints, and performs annual audits to verify completion of consumer satisfaction surveys. Contract vendors are evaluated to assure initiation of appropriate personnel actions including disciplinary actions, policy clarifications and job re-training/orientation. Home care agencies' quality assurance performance is also reviewed as part of HRA's personal care services contract selection criteria.

CONCLUSION

The State of New York takes seriously its responsibility to Medicaid beneficiaries participating in PCSP to assure both access to services and quality of care; its responsibility for program integrity in Medicaid; and its responsibility under The Americans with Disabilities Act and the Olmstead Decision to provide care in community based settings where appropriate. These responsibilities require careful assessment of the regulatory and oversight program to assure these three goals are met. DOH appreciates the OIG's assessment of the program and its operations at the time of the review and has made, and is making, changes to the program going forward to address the issues raised.

DOH strongly encourages OIG to eliminate the draft recommended financial recoveries from the final audit report. Perhaps alternative recommendations could focus on requirements for DOH to: review current regulatory required assessment/prior authorization requirements; promulgate assessment/prior authorization regulations that assure provision of appropriate services to eligible recipients; and conduct statewide local district training in required assessment and prior authorization requirements. Such

alternative recommendations would be consistent with OIG recommendations in other audits.